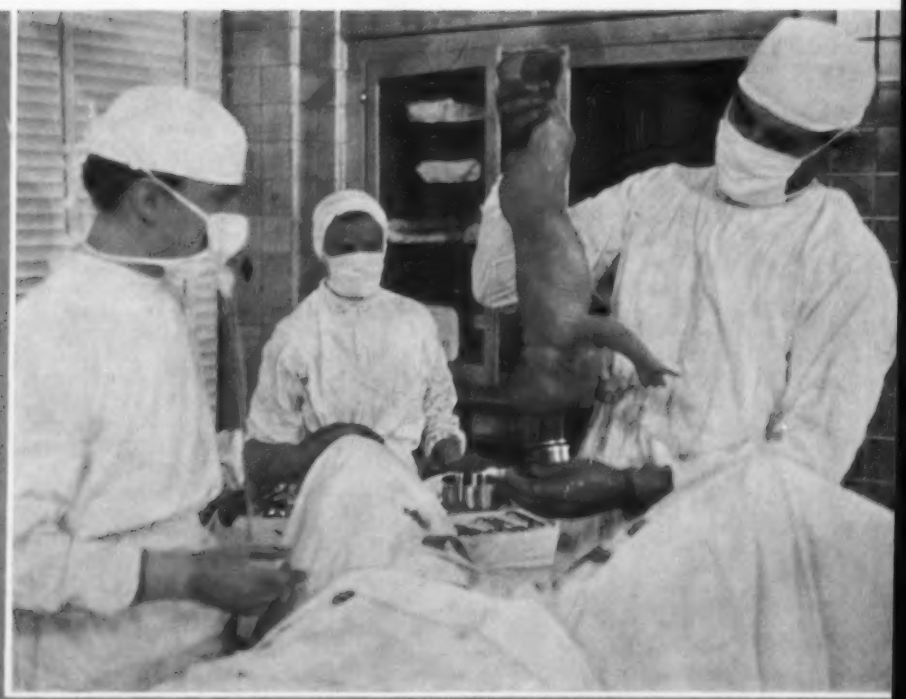
The Modern Hospital

AUGUST 1956



SCENE FROM NEW CATHOLIC HOSPITAL ASSOCIATION FILM (SEE PAGE 88)

Johnson Helps

CUT the COST of COMFORT

in Another Award-Winning Hospital

Sensitive Johnson Room Thermostats insure perfectly conditioned air for operating, delivery and recovery rooms. Thermostats respond to slightest demand for more or less heating or cooling. Cooling coils in operating room floors and relative humidities are also controlled.

Other strategically located Johnson Thermostats and Humidostats maintain ideal conditions in bedrooms. Conditioned air is supplied through overhead outlets. Satisfying temperatures add to patient comfort, help speed recoveries.

Comfortably controlled temperatures help improve working efficiency. To compensate for differences in exposure, the air conditioning system is controlled in four zones—north, east, south and west. Draperies reduce solar effect, lessen the cooling load.

Fayette County Hospital, Vandalia, Illinois. Pace Associates, architects and mechanical engineers, Chicago. Fowler Plumbing & Heating Co., mechanical contractor, Centralia, Illinois.

All-around excellence won it a "modern hospital of the year" award. Besides a pleasing design and an efficient layout, the thoroughly modern Fayette County Hospital offers such amenities as complete year 'round air conditioning, built-in wardrobes, generous storage space for supplies and a toilet in every bedroom. Yet it was built at a cost well below the average for comparable hospitals!

Economies were achieved by meticulous advance planning rather than by sacrificing completeness of facilities. For example, the provision of a high velocity air conditioning system led to enough related savings (such as use of fixed windows, elimination of radiator space) to cut the overall outlay below the cost of providing heat and ventilation only.

Johnson engineers helped by planning a simple but highly efficient air conditioning control system. Temperatures and humidities are accurately and safely controlled throughout the entire building, safeguarding patient health and comfort and increasing staff efficiency. This precision regulation of the air conditioning equipment eliminates heating and cooling waste and results in important operating savings.

Every Johnson installation is specifically engineered and installed to meet the exact needs of the individual building. Whether your particular temperature and humidity control problems involve one room or hundreds of rooms, you can depend on this traditional Johnson policy to insure successful results and cut the cost of comfort.

Ask an engineer from the specialist Johnson organization to help with your control problems on any new or existing building. His recommendations are yours without obligation. Johnson Service Company, Milwaukee 1, Wisconsin. Direct Branch Offices in Principal Cities.

JOHNSON CONTROL

SINCE 1885

PLANNING • MANUFACTURING • INSTALLING

OVER AND OVER AND OVER AND OVER

hospitals re-ordered HAUSTED

EMERGENCY AND RECOVERY ROOM STRETCHERS

Many factors effect a **sale** — personality, friendship, a convincing manner, a good "pitch".

But there is **only one factor** in a re-order — COMPLETE PRODUCT SATISFACTION!

When hospitals re-order HAUSTED stretchers it means they want HAUSTED stretchers over all others, it means HAUSTED stretchers HAVE SOLD THEMSELVES—IN USE—HAVE GIVEN COMPLETE PRODUCT SATISFACTION.

Listed below are some of the hospitals that have re-ordered HAUSTED stretchers FOUR TIMES! Hundreds of others have re-ordered twice, three times, even five and six times!

Ohio State University Hosp.
Columbus, Ohio

St. Joseph's
Denver, Colorado

Halifax District
Daytona Beach, Florida

Homer G. Phillips
St. Louis, Missouri

University Hospital
Cleveland, Ohio

Cabarrus Memorial
Concord, North Carolina

Good Samaritan
Phoenix, Arizona

Kings County Hospital
Brooklyn, New York

Veterans Administration
Dayton, Ohio

Hinsdale San. and Hosp.
Hinsdale, Illinois

St. Mary's Mercy
Gary, Indiana

Lima Memorial
Lima, Ohio

Veterans Administration
Togus, Maine

Medical College
Charleston, S. C.

Marymount
Garfield Heights, Ohio

Baroness Erlanger
Chattanooga, Tenn.

Lewistown Hospital
Lewistown, Pa.

Mayview State
Mayview, Pa.

Middletown Hospital
Middletown, Ohio

McKeesport Hospital
McKeesport, Pa.

Mount Carmel
Columbus, Ohio

Mary Immaculate
Newport News, Virginia

Tampa Municipal
Tampa, Florida

Union Hospital
Fall River, Mass.

the HAUSTED *Manufacturing Co.*

SEE OUR COMPLETE DISPLAY AT YOUR REGIONAL CONVENTION MEDINA, OHIO

The Modern Hospital

AUGUST 1956

VOLUME 87, NO. 2

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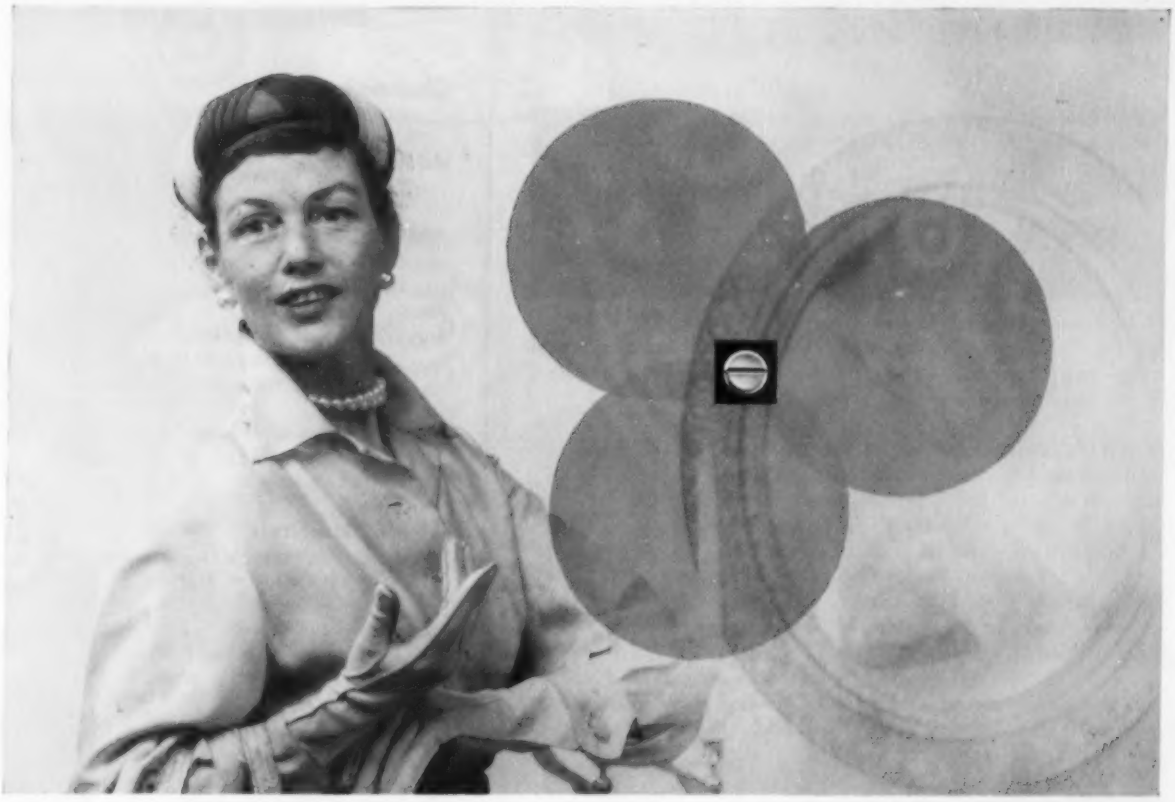

NEW integrated approach to menopausal therapy

'Tylandril'

(DIETHYLSTILBESTROL AND METHYLTESTOSTERONE WITH RESERPINE, LILLY)

relieves emotional tension while restoring hormonal balance

'Tylandril' allows physicians to treat both physical and emotional aspects of the menopause with a single preparation. The androgen-estrogen combination in 'Tylandril' acts synergistically to restore hormonal balance. The presence of 'Sandril' (Reserpine, Lilly) combats psychological tension and helps to alleviate the emotional instability which frequently accompanies the menopause.

Each scored tablet of 'Tylandril' provides:

Diethylstilbestrol	0.25 mg.
Methyltestosterone	5 mg.
'Sandril' (Reserpine, Lilly)	0.1 mg.

Supplied in bottles of 100 (No. 1809).

Lilly

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671083

AMONG THE AUTHORS


Janet Fitzwater

Janet Fitzwater is chief of the surgical nursing service at the Clinical Center of the National Institutes of Health, Bethesda, Md. Before joining the staff of the Clinical Center when it was opened in 1953, Miss Fitzwater was operating room supervisor at the Providence Hospital Division of Catholic University and at Doctors Hospital, Washington, D.C. She is a graduate of Providence Hospital School of Nursing and has her B.Sc. degree from Catholic University of America School of Nursing Education. Her suggestions for improvement of efficiency in the operating room appear on page 56.


Robert A. Anderson

Robert A. Anderson, author of the article on administrator-physician relations on page 51, is superintendent of the Wyoming County Hospital at Warsaw, N.Y., a position he has held for the last eight years. A graduate of the University of Wisconsin, Mr. Anderson took his undergraduate work in journalism and was a newspaperman in New England before the war. After five years' service in the medical department of the army, in hospital units and as aide to the Mediterranean Theater surgeon, Mr. Anderson enrolled in the graduate program in hospital administration at Columbia University, from which he received his master's degree in 1947.


Bernard J. Lachner

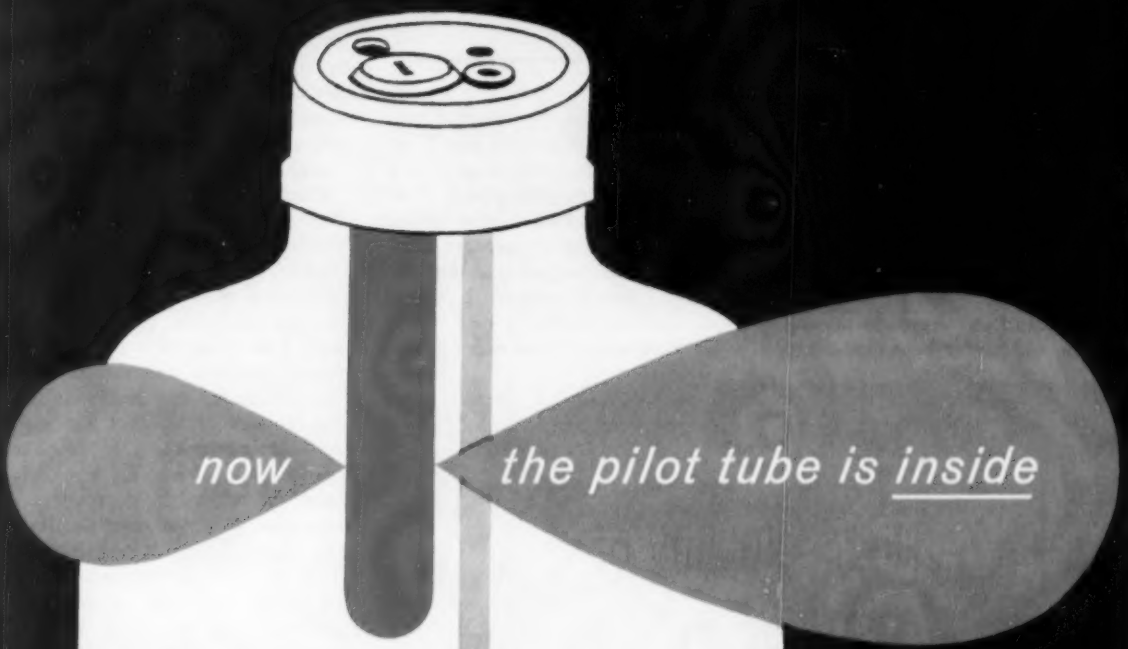
Bernard J. Lachner is assistant director of the State of Ohio Tuberculosis Hospital at Columbus. Mr. Lachner was graduated from Creighton University, Omaha, in 1950 and took his graduate training in hospital administration at the University of Chicago. His administrative residency was served at Iowa Methodist Hospital, Des Moines, where he made the studies on which his article ("Nursing Education Costs Less Than You Think," *p.* 69) is based.


John C. Barker

John C. Barker, author of the article on requisitions on page 66, is assistant director of the Maine General Hospital, Portland. Mr. Barker went to the hospital in 1945, following service with the War Production Board as plant engineer with executive responsibility for care of hospital property, including coordination and management of maintenance departments. He has his degree in engineering administration from the Massachusetts Institute of Technology.


William A. Taylor

William A. Taylor, administrator of Victory Memorial Hospital, Brooklyn, N.Y., was formerly assistant administrator of Children's Hospital, Cincinnati, and his article on "middle management" (*p.* 83) is adapted from a paper presented at the Ohio Hospital Association when he was there. A graduate of Duke University, Mr. Taylor completed the university's graduate program in hospital administration following service with the Medical Administrative Corps during World War II. He was medical administrative officer of the Syracuse, N.Y., regional office of the V.A. from 1946 to 1951.



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blood bottle and tube are **inseparable**—
only one label required

A major advance in blood bottle design, the unique SERA-VAC with its sterile, internal vacuum pilot tube offers these important advantages to hospitals and blood banks—

prevents errors—SERA-VAC's internal pilot tube cannot be mislabeled, interchanged, lost or broken.

saves time—SERA-VAC eliminates labeling and taping of pilot tube to bottle...one less tube to handle.

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READER OPINION

Nurse "Reacts" to Hale Article

Sirs:

I am reacting to the article by Dr. Thomas Hale Jr. on nursing education in the June 1956 issue of The MODERN HOSPITAL.

As a graduate nurse completing my work at a leading eastern university for a master of arts degree in nursing education and having been exposed to the "higher echelons" who are interested in nursing education, may I say that we nurse educators are all vitally concerned with nursing service problems; in fact, so much so that we are continually striving to improve nursing educational programs all over the country. This, of course, is taking much time and effort.

Dr. Hale refers to two major groups in nursing without referring to their names. By his descriptions I recognize the first one as the American Nurses' Association, "primarily concerned with nursing service," of which I am an active member. The other I do not recognize since he states this one, "primarily concerned with nursing education," has "contributed directly to the present acute crisis throughout the nation." I don't know of a large group of nurses, primarily concerned with nursing education, doing this. However, I do know of a large group of nurses, primarily concerned with nursing education, the National League for Nursing of which I am also an active member, which is contributing to the cause of nursing service indirectly by helping to improve nursing education. I would refer Dr. Hale to this organization (2 Park Ave., New York, N.Y.) which would be delighted to supply him with information regarding its purpose and work. I do hope that Dr. Hale will consult both the American Nurses' Association and the National League for Nursing before he publishes another article about nursing service and educational problems.

Both the American Nurses' Association and the National League for Nursing are working together in promoting not just "average good nursing" but rather the greatest number of the very best nurses possible to give *quality* nursing care to patients and their families wherever they may be.

Sheila Garrett, R.N.
48 Howe St.
New Haven, Conn.

Purchaser *Versus* Supplier

Sirs:

I am taking the liberty of offering some thoughts on a letter in your June 1956 issue, in which J. J. Egan comments on Edward Heyd's article ("Sharp Deals Cut Two Ways") in your May issue.

I have talked with Mr. Egan on several occasions regarding the hospital purchaser and supplier relationship, and I am sure that what I have to say will in no way change his thinking. I know Mr. Egan to be a very fine citizen and again I am sure that my remarks will not be taken by him as a personal affront.

I believe Mr. Egan, in his enthusiasm for his way of thinking, makes general statements that cannot be substantiated.

(*Continued on Page 8*)

Moreover, I do not believe that Mr. Egan is fully cognizant that the many problems confronting the suppliers of the hundreds of "daily general usage consumable items" purchased by hospitals differ from the problems of sellers of permanent equipment items.

In Mr. Egan's opening paragraph he states: "The hospitals' practice of obtaining quotations on even small items of purchase is becoming more and more prevalent." Mr. Egan points out that this creates a "pitfall" for the purchaser. I know he does not mean that it is bad business for us purchasers to know the prices of some hundreds of the items we buy.

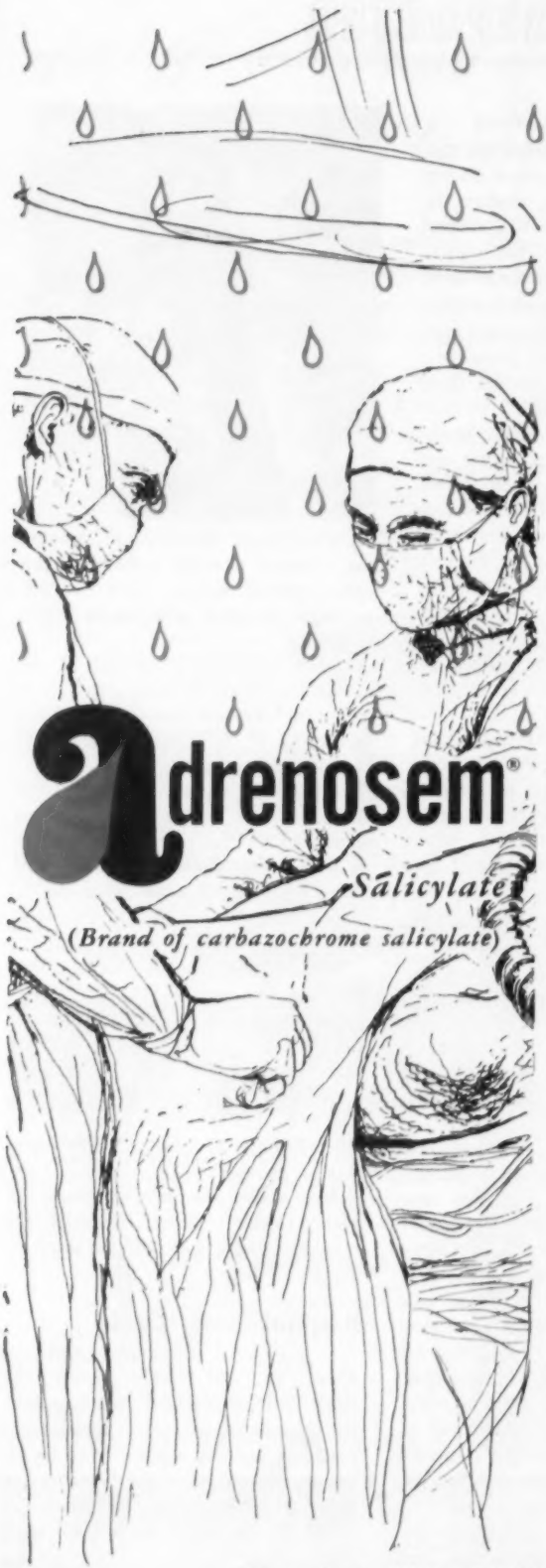
Again, in Paragraph 8 of his letter, Mr. Egan writes: "However, in a price-buying market the quality of an item is often overlooked and, too often, to justify his position in having purchased an item because of low price the hospital administrator or purchasing agent will say that the low priced item is of equal quality to that of the high priced one." I believe here that Mr. Egan has not weighed his words carefully. Although the sentence does not constitute a general condemnation, it seems to me more sweeping than is justified, considering the good business practices of hundreds of people who are doing hospital purchasing.

Again, on Page 8 [of the magazine] a sentence reads: "The storerooms in hospitals that emphasize buying on 'price' are stocked with obsolete items, wrong sizes and types which represent an investment of money and space that some day must be accounted for in the bookkeeping of the hospital." That general statement could lead one to believe that purchasing officers of hospitals generally are not doing a good job. In the few instances of overstocking of storerooms of which I know, the condition is the direct result of the hospital authorities not having adopted *centralized purchasing*. Mr. Egan, as is known, is lukewarm on centralized purchasing. He believes that sales representatives are being stymied under such a system.

Part of Mr. Egan's second paragraph reads: "The supplier has been willing to carry an adequate stock for the hospital to draw on, deliver this stock to the hospital on a moment's notice, show the hospital personnel how to use the item to the best advantage, and, finally, . . . at no charge, to keep the equipment in operating condition." The thinking expressed in the above quotation seems not to agree with that of Carl C. Lamley, whose letter also appeared in your June issue. Mr. Lamley, commenting on Mr. Heyd's article, wrote [Page 10]: "I believe that the growth of hospitals in size and complexity will increase the demand for good maintenance departments and decrease the need for suppliers to concern themselves with some of the fringe services now offered." He continued: "Mr. Heyd's article recognizes the responsibility to purchase equal quality at the lowest price. Suppliers must recognize this responsibility and adapt their sales programs to such a policy."

My experience with hospital suppliers indicates that the purchaser need have no fear about the quality of items he buys, so long as he deals with reliable vendors. But if purchasers failed to pay attention to "the price column," and thus helped to eliminate competition among vendors, they would do a disservice to centralized purchasing.

E. C. Wolf
Director of Purchases
Administrative Assistant
St. Mary's Hospital
Rochester, Minn.



"...specific for conditions characterized by increased capillary permeability."
1

Adrenosem® to control bleeding

Salicylate

(Brand of carbazochrome salicylate)

In his study of 330 hospital cases treated with Adrenosem* Salicylate, Bacala concludes that this systemic hemostat is "specific for the strengthening of capillary resistance."

He summarizes: "Experience with the drug is cited from 317 surgical and 13 obstetricogynecological cases. Most numerous were the 233 tonsillectomies, of which 207 patients were benefited by its use; post-tonsillectomy bleeding was reduced from 19.8 to seven per cent. The drug was also found useful in gastrointestinal bleeding, cataract extraction, epistaxis, incisional seepage, transurethral prostatectomy, menometrorrhagias, cervical oozing, antepartum and postpartum bleeding, threatened abortion, and prevention of capillary hemorrhages during Hedulin or Dicumerol therapy."[1]

1. *Bacala, J.C.: The Use of the Systemic Hemostat Carbazochrome Salicylate, West. J. Surg. 64:88 (1956).*

Supplied in ampuls, tablets and as a syrup.

Write for comprehensive illustrated brochure describing the action and uses of Adrenosem Salicylate.

**U.S. Patent 2,581,850*

The S. E. MASSENGILL company BRISTOL, TENNESSEE

NEW YORK KANSAS CITY SAN FRANCISCO

ROVING REPORTER

Firemen, Come This Way

"We guide our firemen," the administrator of Mercy-Timken Mercy Hospitals, Canton, Ohio, declares in reporting a new idea in fire control developed there. Let's hear what prompted the installation made there in Sister M. Henrietta's own words:

"Suppose that, shortly after midnight, firemen are aroused from their sleep as the alarm gong notifies them of a fire in a local hospital.

"Within minutes they arrive at the scene and in seconds are raising ladders to the sixth floor where flames are shooting out the windows. One man breaks a window and crawls in, only to plunge headlong as he falls over an easy chair which a short time ago had provided comfort for an ambulatory patient.

"As a result of his fall, this fireman can no longer continue on his mission. He must be rescued and replaced. The fire gains headway during the lost time."

The situation described can happen in hospitals, Sister M. Henrietta asserts, for it has proved disastrous in warehouses and other public buildings. However, Mercy-Timken Mercy Hospitals found a way to do away with this hazard at small cost.

This is what happened there: Capt. Kenneth Ash of the Canton Fire Prevention Bureau visited the hospital one day and asked the administrator to mark windows where safe and easy entrance from fire ladders might be made.

After careful consideration and numerous tests, the hospital officials decided that use of a luminous tape was the most efficient way they could devise for marking the windows selected. Tests indicated that the tape (trade name available from the hospital) would adhere to any surface, was weather resistant, would not deface the building, and—most important—was visible both day and night. The decisive test was conducted at night with a small flashlight projected to the sixth floor. Reflection was excellent from all angles.

The tape chosen is available in several colors and is similar to that used for traffic marking.

City fire officials participated in the tests, and after thorough study asked

Luminous tape indicates to firemen the windows through which they can enter without danger. Tape has advantage of good visibility at night.

that the markings be placed in the middle or designated windows. Choice of the mid-window area eliminated the possibility of the tape's being hidden by screens or window frames.

It has been eight months or more since the tape was installed. It has shown no ill effects from the weather or from repeated washings. The tape was cut in strips 3 inches wide and 10 inches long. It took only a few hours to cut and affix it.

When all the window markers were in place and tested, the local newspaper carried a picture and feature story on the new system. A statement from Captain Ash commended hospital officials for their alert cooperation and urged managers of other Canton buildings to mark windows in a similar manner.

Meanwhile, the fire programs at Mercy-Timken Mercy Hospitals are regularly being surveyed to improve fire prevention.

Hospital Credit Cards

If you lived in or near Newport News, Va., and were a person who paid his bills promptly and regularly, the chances are you would find in your mail box one day a letter from Dr. E. Stanley Grannum on the letterhead of Whittaker Memorial Hospital, of which Dr. Grannum is the administrator.

A neat little card with your name and address on it would fall into your lap when you opened the letter. The

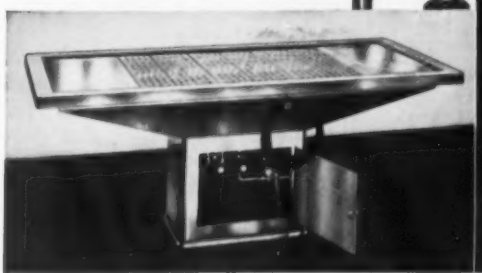
for Effective Sanitation
for Faster Cleaning

IN THE AUTOPSY ROOM

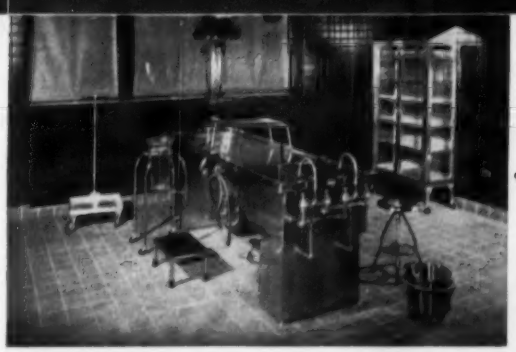
BLICKMAN-BUILT Stainless Steel AUTOPSY TABLES

• In the autopsy room, where constant clean-ups are necessary, these polished stainless steel autopsy tables save time and labor. Smooth, crevice-free surfaces, rounded corners and coves facilitate cleaning—protect presonnel through better sanitation. Carefully-planned drainage systems are further important aids to cleanliness. All accessories are functionally designed and conveniently placed to promote efficiency. Strong welded structures assure durability, keep repair and maintenance costs to a minimum. In terms of sanitation and long service life, it pays to invest in Blickman-Built autopsy tables.

HARTFORD Model Entire unit forms a completely-welded, crevice-free stainless steel assembly, assuring sanitation and long service life. Removable crossbars rest on ledges which are perforated so that entire trough may be thoroughly flushed. Removable stainless steel tray is mounted on adjustable standard.



ENDICOTT Model: Unusual design conceals piping and valves. Trough slopes sharply to central waste outlet. Continually flowing water plays over entire inner surface. Five top grids are removable, facilitating cleaning.

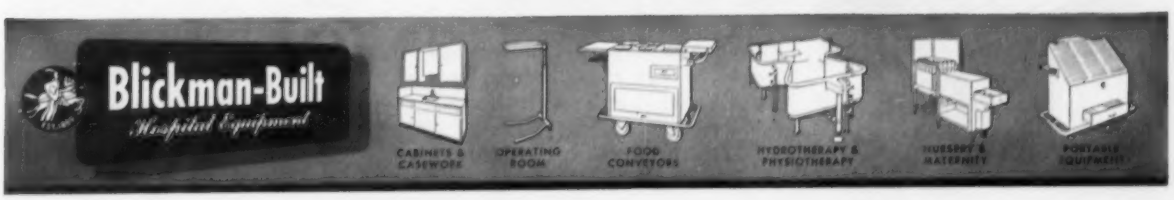


Autopsy Room Typical autopsy room in the Medical Center, Jersey City, N. J. Planned and equipped by S. Blickman, Inc., it has been rendering efficient service for many years. Consult us about complete installations, designed to meet your specific requirements. Layout and engineering service available.

SEND FOR BULLETIN No. 5 ATC describing, with complete specifications, these and other models of Blickman-Built Stainless Steel Autopsy Tables.

S. BLICKMAN, INC.

1508 Gregory Avenue, Weehawken, N. J.



card would have the name of the hospital and a sketch of the building on it, a serial number and the date "1956," and a place for your signature.

The letter would read as follows:

"During the time of an emergency every moment is precious. We feel that this is most emphatically true at the time of admitting a patient. Because so much essential data are necessary for the proper admission of the patient and is so time consuming, the administration has thought of ways and means whereby its friends may be spared some of this delay.

"Our records show that you have demonstrated an appreciation of the fact that it is necessary for us to depend upon prompt payment by our patients to enable us to be prepared for such a contingency.

"To this end, the board of directors of this institution, by virtue of your past demonstration of friendly interest in the perpetuation of this hospital, has authorized me to issue this introductory credit card.

"This will enable the admitting clerk to be aware of your dependability and thus accelerate and modify the admitting process. We hope that you will sign the card immediately for identification purposes if you intend to use it and, if not, please return same to this office immediately so that your registration may be changed.

"This card must be presented by the person whose signature is affixed. It is anticipated that this card will be of mutual benefit."

They Know What to Expect

Maternity tours are a monthly event at St. Joseph's Hospital, Burbank, Calif. As the name indicates, this event precedes a blessed event, and it is open to both prospective mothers and fathers.

Usually there are from 100 to 150 pregnant women in the tour. They join the group on advice of their doctors.

The tour begins with a coffee hour in the hospital auditorium. There the expectant mothers, and any husbands who may have come along, are briefed on childbirth procedures at the hospital.

The guides take them to see the maternity department's eight labor rooms, three delivery rooms, cesarean section rooms, the 52 maternity beds, and the 62 bassinets.

They learn that the husband, properly outfitted in a surgical gown, may visit with his wife during the early stages of labor at the discretion of the supervising nurse. Husbands are not allowed in delivery or operating rooms, they are told.

The group learns that the husband is summoned to the delivery room immediately after the infant is born to identify the mother and child and to check the spelling on the name beads placed about the infant's neck. He also signs the newborn record that bears the infant's footprints and the mother's fingerprints.

Visitors learn, too, that at St. Joseph's all newborns spend the first few minutes of their lives in the delivery room incubator, which is kept warmed and operating at all times.

The hospital finds that, owing to the tours, young mothers come to the hospital with less apprehension; the fathers, too, suffer less acutely during their ordeal.

Disposing of Wastes

A food disposer unit has been put to practical use outside the surgical suite in a southern California hospital. Originally, the kitchen waste disposer was installed in the delivery room and used for the immediate disposal of placentae and other human materials into the waste lines.

Locating the waste disposal unit near the surgery made it possible to dispose of a greater volume of waste material. It was thought that there might be objections to carrying waste material from surgery to the maternity suite, whereas the reverse would offer no difficulties.

Before the food disposer unit was installed, it had been the custom to take the placenta, put it in a small bag, and place it in a deep freezer. When the freezer was full, a scavenger firm was paid to carry the material away and burn it. This proved a fairly expensive process.

The disposal unit now in use in the hospital is not the home kitchen type but is of heavy duty, commercial construction and is powered by a ¾ h.p. motor. It grinds the material placed into it through an opening that has a tolerance of 5/1000 to 8/1000 inch before it goes into the scavenger bowl and then into the waste line under pressure.

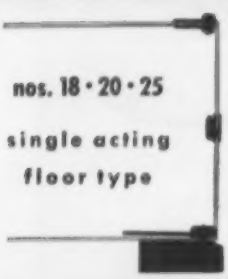
Impressed by the idea, the Hospital Council of Southern California described the system in one of its bulletins to members.

there's a RIXSON concealed closer or pivot set for every door

ENTRANCE • VESTIBULE • INTERIOR

According to your requirements in appearance, hanging style, function and construction detail, YOU CAN SPECIFY RIXSON THROUGHOUT.

offset hung



nos. 18 • 20 • 25
single acting
floor type

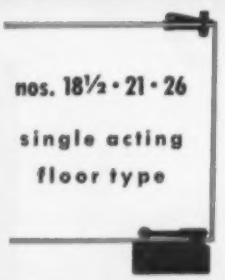
for entrance, vestibule and interior doors—where full unobstructed door opening space and wide door swing (to 180°) are important. Special styles are available for fire doors and x-ray room doors. Arm locking arrangement allows vertical adjustment of door.

offset hung

UNI • CHECKS
nos. 65 • 66 • 67 • 68
single acting
floor type

for interior room doors—where full unobstructed door opening space and wide door swing (to 180°) are important. Depth of 2½" (including cement base) to suit shallow floors. Special styles meet Underwriters' Laboratories approval for fire doors.

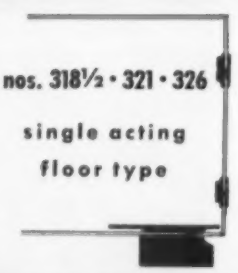
center hung



nos. 18½ • 21 • 26
single acting
floor type

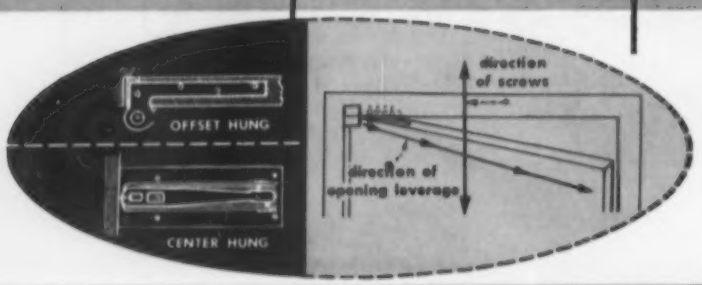
for entrance, vestibule and interior doors—where concealment of both closer and door hanging hardware is desirable when door is open or closed. Ideal for batteries of doors. No mullions required, allowing utmost use of entrance area.

butt hung



nos. 318½ • 321 • 326
single acting
floor type

for entrance, vestibule and interior doors—where it is desirable to have door hung independently from closer. RIXSON ball hinges, featuring vertical adjustment, are generally specified for door hanging.



Because screws are at right angles to opening leverage, pivotal hung doors are more securely attached—less apt to pull away from the jamb.

conceal the closer and expose the beauty of the door

center hung	center hung	butt or center hung	offset and center hung
nos. 30 • 40 double acting floor type	DUO • CHECKS nos. 10 • 12 • 15 • 16 • junior double acting floor type	nos. 218 • 220 • 225 nos. 218½ • 221 • 226 single acting overhead concealed	MATCHING PIVOT SETS nos. 117 • 117¼ • 117½ L117 • 117¾ single acting concealed
for entrance, vestibule and interior doors that swing both in and out with each swing separately adjustable to local wind and draft conditions. Both the closer and door hanging hardware are completely concealed.	**for interior room doors**—where double door swing and complete concealment of door hanging and closer hardware are desirable. These closers are ideal for hospital and restaurant doors where people pass through with hands occupied.	**for entrance, vestibule and interior doors**—where it is desirable to conceal closer in jamb above door. Compact size, 2⅛" x 2⅝" x17", makes closer ideal for modern, narrow trim installations. RIXSON adjustable ball hinges are recommended for use with No. 218 series.	**for pivotal door hanging only.** Match the hanging style and general appearance of doors with RIXSON offset or center hung closers. Widely used on inactive doors such as on closets and wardrobes. Styles available for all doors from the lightest to the heaviest.

write for full information on any RIXSON device

THE OSCAR C. RIXSON COMPANY

9100 west belmont avenue • franklin park, illinois

LAWRENCE BEALL SMITH

In Florence, too, Pentothal serves almost constantly

reflecting . . . a world-wide acceptance
rarely attained in modern medicine

Wherever modern medicine is practiced, you'll find Pentothal Sodium used as an agent of choice in the management of anesthesia. Seldom in the history of medicine has a single drug achieved the eminence that is Pentothal's. More than 2400 published medical reports, and over 20 years of use, have made it worthy of your trust. Abbott

PENTOTHAL® Sodium

(Thiopental Sodium for Injection, Abbott)


no pain . . .
no memory . . .
no nightmare of fear
in pediatric anesthesia
When you choose Pentothal Sodium by rectum as the basal anesthetic, or as the sole agent in minor procedures, you spare your young patients an unnecessary ordeal of fear and anguish. With Pentothal Sodium administered rectally, the child goes to sleep pleasantly in his own bed . . . and awakens there after surgery with complete amnesia of the events between. Events, that in his sensitive mind, might cause lingering post-operative anxieties, creating new behavior problems for his parents.
And because Rectal Pentothal reduces the dosage of inhalation and supplementary agents, after-effects are markedly lessened. It offers a notably safe, simple and humane approach to pediatric anesthesia. Do you have the literature?
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PENTOTHAL®
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(Thiopental Sodium, Abbott)
by rectum
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EASIEST-QUICKEST WAY

to take a footprint...

Only $9.50 — and one low price includes everything needed — attractive nylon plastic case that fits the hand comfortably, and the remarkable, replaceable "Dry Plate", an exclusive Hollister development.

the FootPrinter by Hollister

Easiest — by far! Quickest — by far! And by far cleanest! The beauty of it is, the baby footprint you take with the Hollister "Dry Plate" FootPrinter is *clear* . . . So clear and precise when the simple directions are followed that the fine lines and tiny whorls of the baby's delicate skin are sharply recorded.

See other side of this page for FREE TRIAL offer

Saves MINUTES per baby...
HOURS per week!

1. No mess . . . just press!

Here's one foot printer that requires *no roller, no inking,* no messing with inks that stain hands, often ruin uniforms. Just press the baby's foot against the "Dry Plate" of the Hollister FootPrinter. . .

2. Apply foot to chart sheet.

Gentle but firm pressure for an instant is all that's required. The high gloss surface of Hollister Kromekote chart sheets yields the best print of all. Lift foot off paper and the print's made!

3. Perfect prints in seconds.

It's the fine lines that count! And the Hollister FootPrinter easily records the delicate lines and whorls as no other method can do. That's what's important in taking baby prints.

4. No messy clean-up!

The color of the FootPrinter is deposited only on the top of the ridges of baby's skin and most of it transfers to the paper. A quick, light sponging removes the last trace of soil.

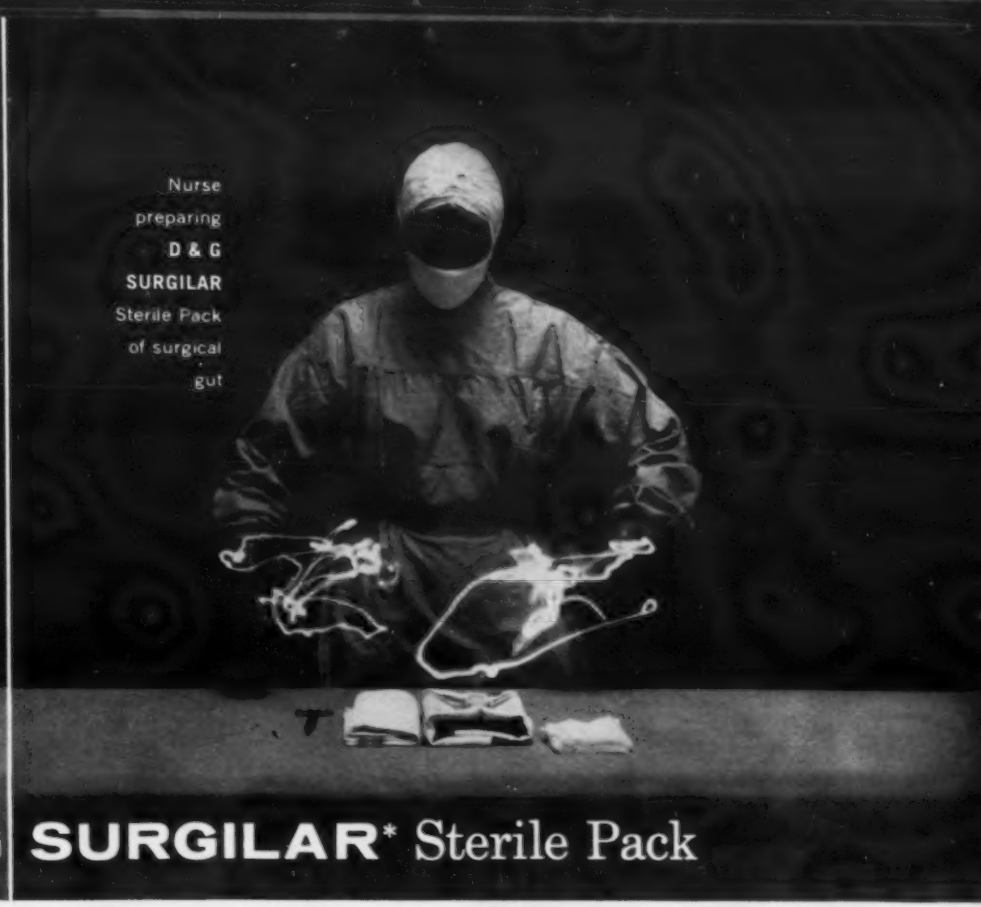
Franklin C. Hollister Co., 833 N. Orleans St., Chicago 10, Ill.
. . . Please send me a FootPrinter on 10 days free trial with the understanding that I may return it within that time without cost or obligation. If you have not heard from me within that time, please send invoice for $9.50 to—

HOSPITAL _____

ADDRESS _____

BY _____ TITLE _____

Hollister invites you to accept the FootPrinter for 10 DAYS FREE TRIAL!



Save suture handling with D & G SURGILAR* Sterile Pack

GET BROKEN GLASS OUT OF THE O.R.

Light-tracings in the time-and-motion pictures show a nurse's hands at work. Compare the simple motions she uses to prepare SURGILAR Sterile Pack of surgical gut with the many motions for tubed gut. She can handle SURGILAR ⅓ faster than tubes.

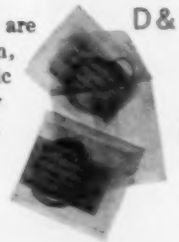
SURGILAR saves hospital nurse-power and money. It eliminates glass tubes, provides stronger, more flexible D & G surgical gut coiled in quickly opened, double, sterile transparent envelopes.

*Trademark

Hospital-tested SURGILAR helps to improve patient care. It keeps broken glass out of your O.R. No glass fragments to damage sutures, cut fingers, perforate gloves, or invade the operative field.

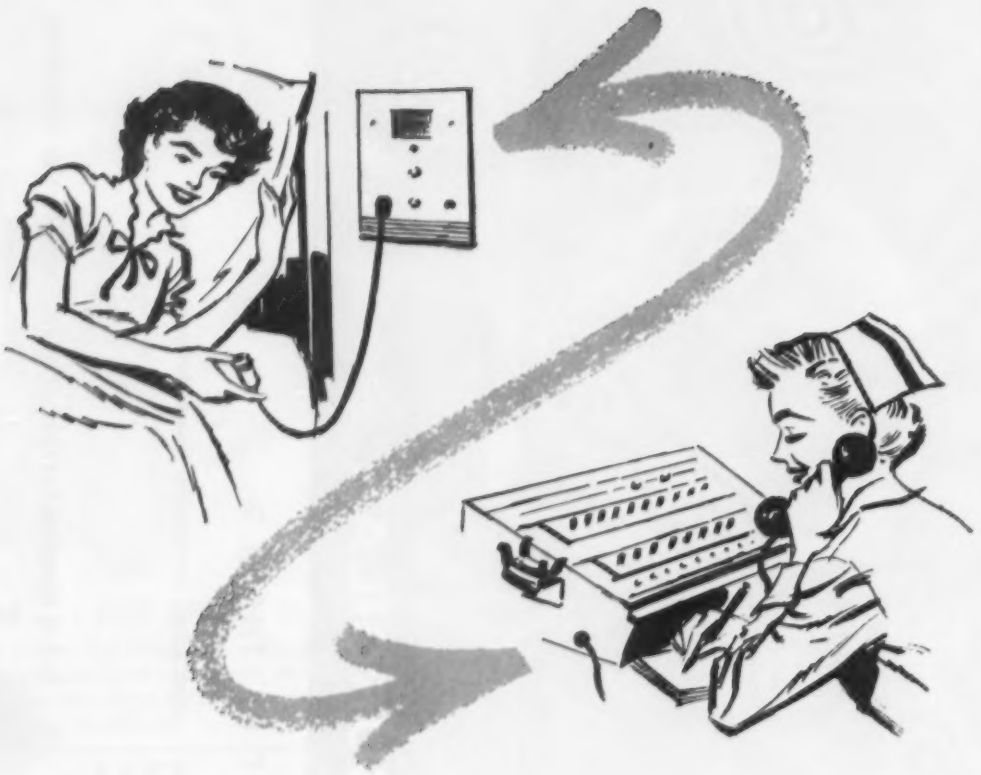
With SURGILAR, double envelopes are quickly cut, gut easily withdrawn, ready for use. No need to wash plastic envelopes after exposure, since they are protected by the outer envelopes. Jars store in ½ space required for tubed gut.

photo technic: *light-tracings of hands to which bulbs are attached.*



D & G **hospital-tested** packaging makes the difference

DAVIS & GECK
A DIVISION OF AMERICAN CYANAMID COMPANY
DANBURY CONNECTICUT



Edwards audio-visual call system assures

efficient patient care!

Qualities you can see and hear in any Edwards hospital installation demonstrate the *assurance* of efficiency and dependability of Edwards Audio-Visual Call Systems. Clear, supersensitive patient-nurse communication, without distortion or interference, results from Edwards matched design of quality components.

Stainless steel is the standard finish for patient stations, so they're always attractive, unobtrusive, and neat. Even the keys on the master station are extra quality: the long-life telephone switchboard type that last for years and years.

"Plug-In" construction of vital parts is standard. It takes only a few seconds to unplug and remove components, assuring you twenty-four hour service without expensive maintenance costs.

Attractive, clean, modern design harmonizes with and enhances hospital decor. All the features of operation you need to help your nurses give their patients better care have been built into Edwards Audio-Visual Call System. Get complete information . . . write Edwards Company, Inc., Dept. MH-5, Norwalk, Connecticut. (In Canada: Edwards of Canada, Ltd., Owen Sound, Ontario).

Specialists in signaling since 1872

EDWARDS

DESIGN • DEVELOPMENT • MANUFACTURE

Get more efficient housekeeping from present manpower and equipment with this new work planning guide

It provides a methodical, orderly system for scheduling the daily work of the maintenance crew.

- Makes planning the work day simple.
- Gives each worker an "at-a-glance" picture of what he is required to do.
- Makes supervisor's follow-up easy.
- Provides convenient record of work accomplished—and when.

Plus suggestions on building maintenance—ideas to speed the job and ease the load—tips on caring for mechanical equipment—tips on maintenance methods for various kinds of floors.

MAIL COUPON TODAY FOR FREE WORK PLANNING GUIDE

ADVANCE

ADVANCE FLOOR MACHINE CO.
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☐ Yes—we'd like our Work Planning Guide.
☐ Also send literature on Advance vacs and floor machines.

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For Floor Cleaning Jobs you can't beat this *Performance Pair*

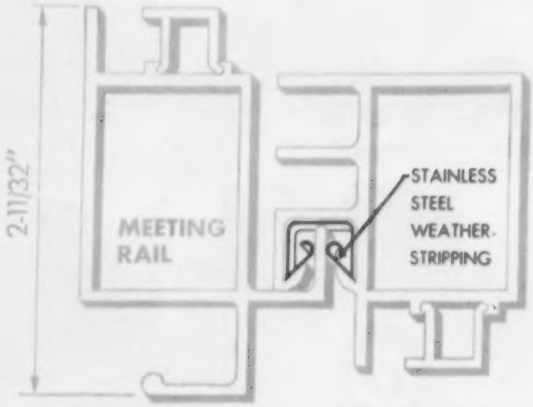
ADVANCE
Speedboy Deluxe
The modern method of scrubbing, waxing, polishing and steel wooling to give floors tip-top appearance and long life with a minimum of maintenance time.

ADVANCE
Hydro-Jet
WET OR DRY VAC
A powerful, heavy duty vac for wet or dry pickup on rugs and floors. Special attachments for cleaning blinds, walls and furniture.

Floor maintenance goes better and faster with proper equipment. When you buy Advance quality you get more performance per dollar invested. And you save more than enough in labor cost to pay for the equipment. Drop us a postcard or mail the coupon for full details!

Front elevation of Grossmont District Hospital, San Diego, California presents interesting pattern of light and shade, with Ceco-Sterling Aluminum Double-Hung and Fixed Windows and Screens providing echo accents for the main motif. Pereira & Luckman, planners, architects and engineers.

There's minimum air infiltration with the use of Ceco-Sterling Double-Hung Monumental and Commercial Windows, Series 200-B. That's because the sash float on stainless steel weather stripping, assuring tight, freely operating, vertical sliding windows. They operate silently, so necessary in hospital windows.



Note the heavy extruded box sections for rugged performance, and the double-contact stainless steel weather stripping for tightness. Similar weather strip at jambs provides a spring cushion contact, holds sash clear of frame for easy sliding.

The sweep and pattern of the window treatment lend stately drama to Grossmont. Visors over the windows and right-angle fins control glare while admitting abundant light.

WINDOW TREATMENT IN A HOSPITAL

...BUILDS PATIENT MORALE

ONE WHOLE WALL OF EVERY ROOM IS MADE INTO A PICTURE WINDOW BY COMBINING CECO-STERLING ALUMINUM DOUBLE-HUNG AND FIXED WINDOWS . . .

The therapeutic value of sunshine and view had much to do in guiding Pereira & Luckman, planners, architects and engineers of Los Angeles and New York City, in designing the Grossmont District Hospital. To give patients a better outlook they made the whole side of each room into a wall of glass—a picture window bringing in sunshine and acres of view.

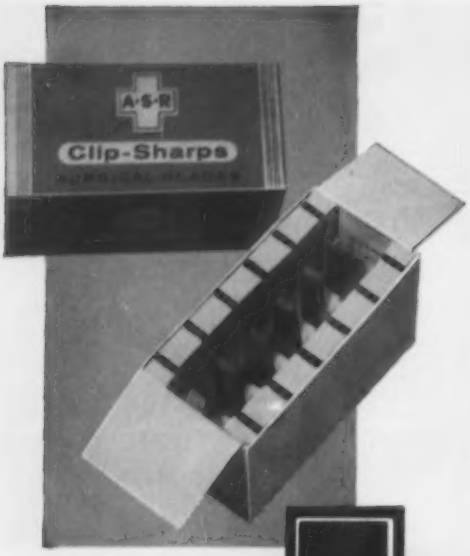
Ceco-Sterling Aluminum Double-Hung and Fixed Windows accomplished the desired effect. Maximum glass was possible because of slender sleeving mullions and narrow sash sections. And important, too, was the tight weather-seal provided by Ceco Windows. On your next building project, consult Ceco Engineers. They will help you make effective use of metal building products.

CECO STEEL PRODUCTS CORPORATION

Offices, warehouses and fabricating plants in principal cities
General Offices: 5601 West 26th Street, Chicago 50, Illinois

IN CONSTRUCTION PRODUCTS CECO ENGINEERING MAKES THE BIG DIFFERENCE

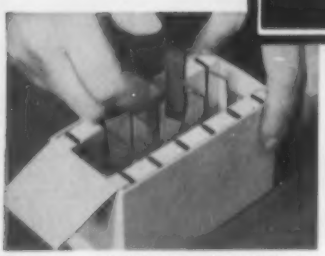
Windows, Screens and Doors / Ceco-Meyer Steelforms / Concrete Reinforcing / Steel Joists / Metal Roof Deck / Metal Lath



now! quick, easy blade sterilization with

A·S·R Clip-Sharps

TRADE MARK



Remove cover – hold box in one hand. With other hand lift one wire holder (24 Blades) from box.

Grasp the wire clip between thumb and index finger and squeeze the wire. This releases the tension and enables the blades to be easily removed from the clip.

Holding the blades between thumb and index finger, simply slip them onto the rack. It's quick – and easy!

Clip-Sharps® are convenient wire clips containing 24 unwrapped A.S.R. Command Edge Surgical blades. There are six clips per box, protected by rust inhibiting paper.

Any sterilizing rack and any reliable, non-corrosive sterilizing agent may be used.

If you do not wish to sterilize the entire clip of 24 blades, remove only the required number from the clip and place them on the rack arm.

All A.S.R. Surgical Blades are Sharpometer tested. The A.S.R. Sharpometer, *only* device of its kind, measures the critical edge-fineness of every lot of A.S.R. Surgical Blades. These tests enable A.S.R. to guarantee . . . precise, uniform sharpness and dependability for every single blade!

NOW: For extra convenience, blades are alternated on clips.

Available through your Surgical Dealer.
Write for further information.

A·S·R **HOSPITAL DIVISION**
AMERICAN SAFETY RAZOR CORP.
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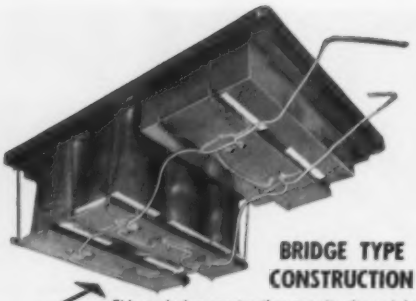
NEW YORK 17, N. Y.

H-3

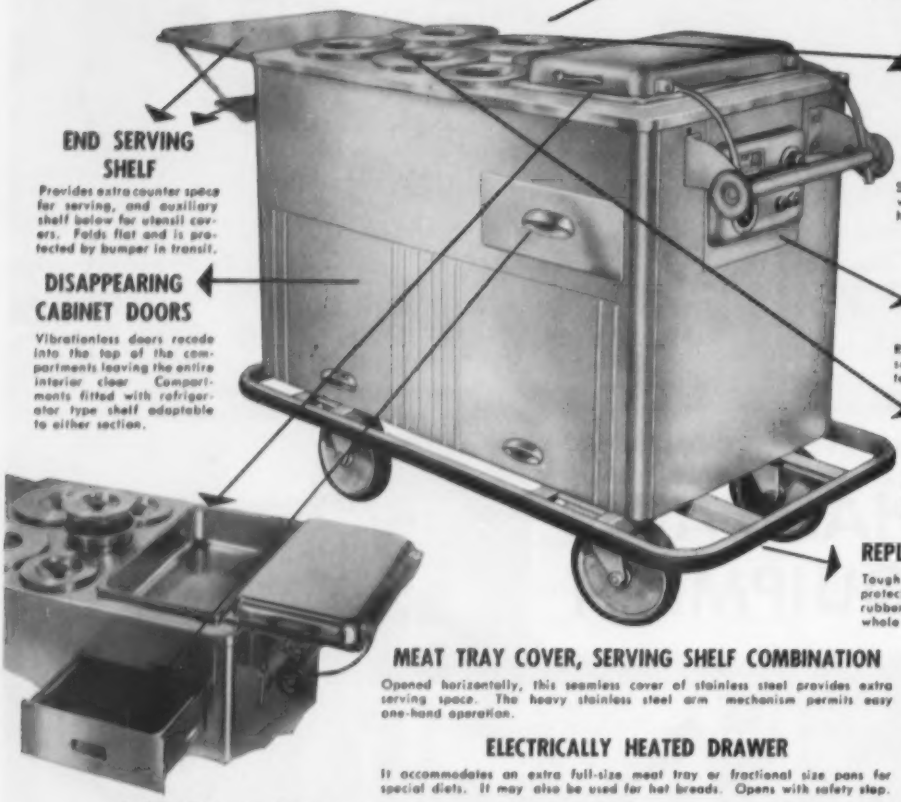
IDEAL FEATURES

make your food service EASIER...



BRIDGE TYPE CONSTRUCTION

This exclusive construction permits the weight of food and utensils to be carried through the frame to rest on the chassis. The 20-gauge stainless steel top deck cannot sag, and can carry considerable extra weight without damage. Only Ideal gives such extra strength, plus lifetime durability.



END SERVING SHELF

Provides extra counter space for serving, and auxiliary shelf below for utensil covers. Folds flat and is protected by bumper in transit.

DISAPPEARING CABINET DOORS

Vibrationless doors recede into the top of the compartments leaving the entire interior clear. Compartments fitted with refrigerator type shelf adaptable to either section.

INSULATED COVERS

Seamless plug covers are fully insulated with fiber-glas to insure minimum heat loss.

AUTOMATIC TEMPERATURE SELECTOR

Robertshaw Automatic Thermostat assures foods at original hot serving temperatures.

SEAMLESS UTENSILS AND WELLS

Round utensils, meat trays and wells are seamless 20-gauge stainless steel. Large rims on utensils for easy lifting and offset shoulders for perfect cover seal.

REPLACEABLE BUMPER GUARD

Tough aluminum bumper assembly fully protects body of conveyor. Clincher type rubber bumper guard easily replaced, in whole or part.

MEAT TRAY COVER, SERVING SHELF COMBINATION

Opened horizontally, this seamless cover of stainless steel provides extra serving space. The heavy stainless steel arm mechanism permits easy one-hand operation.

ELECTRICALLY HEATED DRAWER

It accommodates an extra full-size meat tray or fractional size pans for special diets. It may also be used for hot breads. Opens with safety stop.

*** Shown above is Ideal Food Conveyor Model 1431, capacity 60 to 120 meals. Other models available with capacities from 20 to 500 meals.**

Ideal hospital equipment, made only by Swartzbaugh, is specially designed—inside and outside—to fit your need for maximum efficiency, fingertip convenience and lasting utility. That's why Ideal equipment items—food conveyors, tray conveyors, sterilizers and therapeutic equipment—are found in leading hospitals everywhere.

Write for **FREE** *full-line catalog*

Ideal HOSPITAL EQUIPMENT *Found in Foremost Hospitals*

HIA

Made only by the

SWARTZBAUGH MANUFACTURING COMPANY

MURFREESBORO, TENN.

Cloverlane comes in smart pastel colors that you can mix or match. Complete line of pieces now available . . . even including serving platters.

it's new... it's beautiful... it's Cloverlane

The melamine dinnerware designed for hospitals

There's no 'institutional look' to this newest dinnerware . . . yet it's practical down to the very cup handles. It's CLOVERLANE . . . with beauty and functional high-style. It's CLOVERLANE . . . designed solely for mass feeding with all these features:

Practically Unbreakable — CLOVERLANE is virtually indestructible. Even when subjected to the most severe use it should cut replacement costs *at least* 50%.

Faster Washing and Drying — CLOVERLANE's smooth, contoured surfaces and its aerated base speed washing, rinsing, and drying . . . minimize spotting. And CLOVERLANE can take the hottest water your automatic dishwasher can handle.

Easy Stacking — No Sticking — The exclusive design of CLOVERLANE dishes permits constant air circulation . . . prevents dishes from sticking together, even when stacked damp.

Better Handling — CLOVERLANE is designed for ease of handling. CLOVERLANE cups, for example, have recessed thumb rests that aid balance and minimize spillage. And CLOVERLANE's light weight makes light work of lifting large tray loads.

Besides these exclusive features, CLOVERLANE has all the other advantages of melamine dinnerware. It's quiet—there's no rattle and clatter — its insulating properties help keep food hot or cold and eliminate the need for warming dishes. Ask your dealer about CLOVERLANE and write for full color brochure. No obligation, of course.

Dinnerware Division
Chicago Molded Products Corp.
1015 N. Kolmar Avenue
Chicago 51, Illinois

Send full details on Cloverlane.

Name_____

Company_____

Address_____

City_____ Zone_____ State_____

now, Crucible low nickel stainless steels that meet many of your needs...

Here are two *new* Crucible grades, Rezistal type 201 and 202 that are similar in quality and properties to types 301 and 302 . . . but with desirable features all their own.

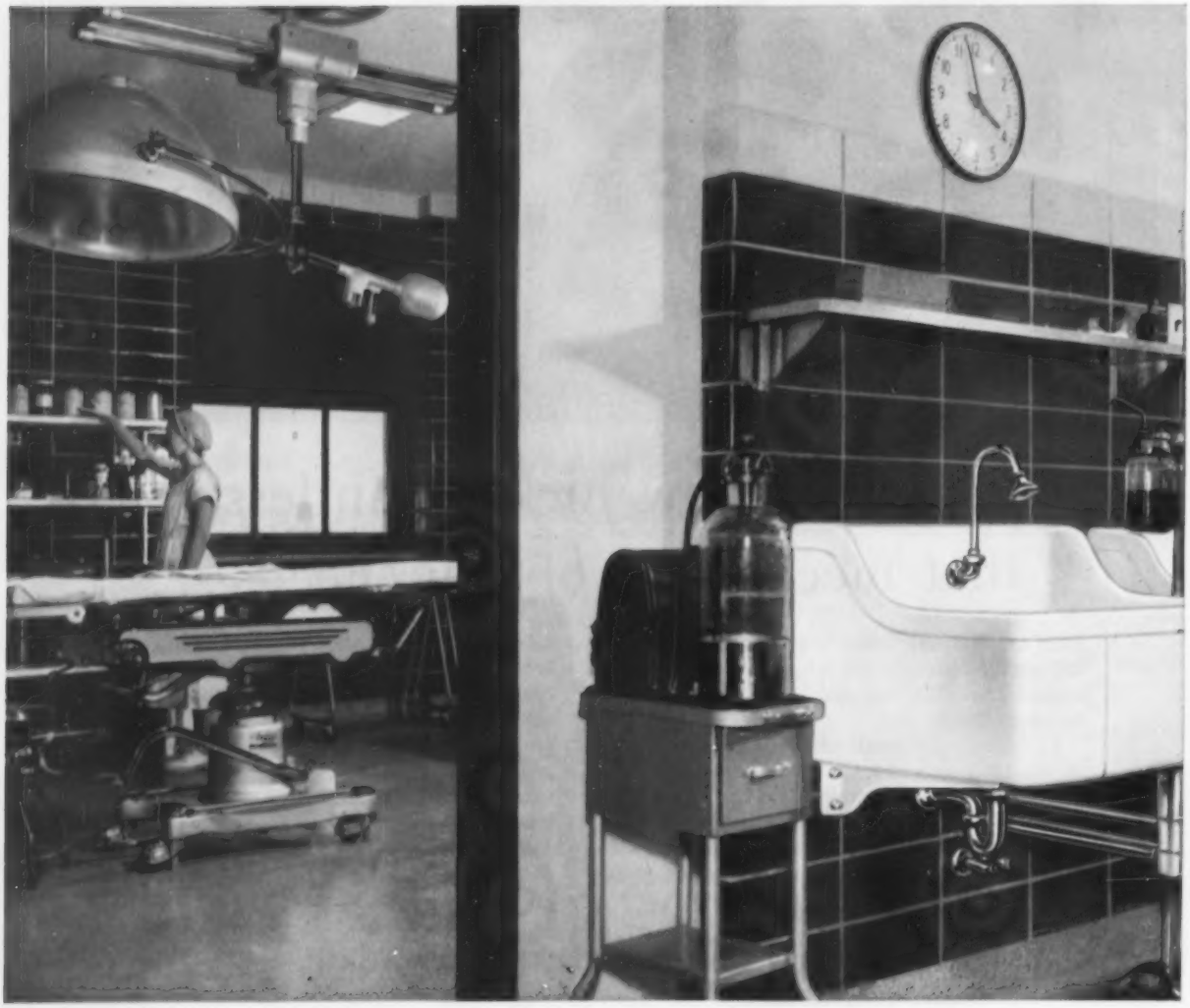
In the annealed condition, for example, Rezistal 201 and 202 have about 10% higher strength than 301 and 302, yet maintain almost identical ductility. This means that these grades can be fabricated with ease equal to their counterparts. In addition, their mill finishes and corrosion resistance to a wide variation of media compare most favorably with 301 and 302.

To sum up: Rezistal 201 and 202 have practically all the desirable properties of 301 and 302, *plus* some of their own. And they're available *promptly* in all forms. Write now for data sheets fully covering the properties of these new stainless grades. *Crucible Steel Company of America, Dept. AMH, The Oliver Building, Mellon Square, Pittsburgh 22, Pa.*

CRUCIBLE first name in special purpose steels

Crucible Steel Company of America

Canadian Distributor—Railway & Power Engineering Corp., Ltd.



A scrub-up sink that's easy to keep sterile. This special vitreous glazed, all-ceramic product resists thermal shock, abrasion, acid and stains. Withstands expansion and contraction without crazing. Special shape permits surgeon to scrub to shoulder without touching unsterile parts.

CRANE

leading specialist in hospital plumbing?

If you ask your architect, he'll probably tell you that Crane is the outstanding authority on hospital plumbing for two reasons:

1) Crane carries on continuous research, keeping abreast of the newest hospital techniques.

2) Crane uses this information to develop a complete line of fixtures as specialized for today's hospital as your x-ray equipment.

This means that when your hospital is Crane-equipped, it's as modern in its plumbing as in its radiological laboratories. Because every fixture is specially designed for its particular job, repair and maintenance problems, of course, are reduced to a minimum.

Why not talk to your architect about Crane. You'll find he agrees with your preference for Crane hospital fixtures.

Crane Hygiene lavatory designed especially for patients' and nurses' use. Has integral shelf for water pitcher, toilet articles and other patient needs. Six-inch-high end splash optional. Equipped with wrist-action Dial-ese controls for easy and positive operation. Crane Dial-ese means longer life—less maintenance.

New from Crane. This emergency bath of Duraclay is one of the specialized fixtures developed by Crane for hospital use. Its shallow depth aids in movement of patient from and to litter. Has thermostatically controlled water supply with Deviator spout for diverting water to spray. Vacuum breaker safeguards sterile water supply against back siphonage.

CRANE CO. General Offices: 836 South Michigan Avenue, Chicago 5

VALVES • FITTINGS • PIPE • KITCHENS • PLUMBING • HEATING

Castle's Automatic Instrument WASHER-STERILIZER

NEW "PUSH-BUTTON" No. 200 . . . here is the ultimate in aseptic efficiency! From the touch of a single control button, a motor driven valve selector controls the entire uninterrupted cycle, insures faster attention-free processing of surgical instruments without possibility of error.

Saves time – the moment starter button is pressed, operator is freed for other duties. No watching of gauges or return trips to turn valves. Complete automatic cycle precludes danger of technique shortcuts . . . conserves nurse's time.

Saves time – speed and simplicity of 15 minute operation encourage rigid instrument routine. Unit rinses, soaks, scours soiled instruments much faster and far more thoroughly than manually possible.

Saves time – after cleaning, instruments are sterilized at 270°F. and flash-dried for instant return to surgery, when necessary. Technique shortens critical waiting time, cuts instrument inventory requirements.

Also Featured

DUAL-LOCK SAFETY DOOR — gives double protection. Incorporates pressure diaphragm lock inside, safety lock outside. Avoids hazard of non-lock or single lock doors . . . cannot be opened until pressure is reduced to zero.

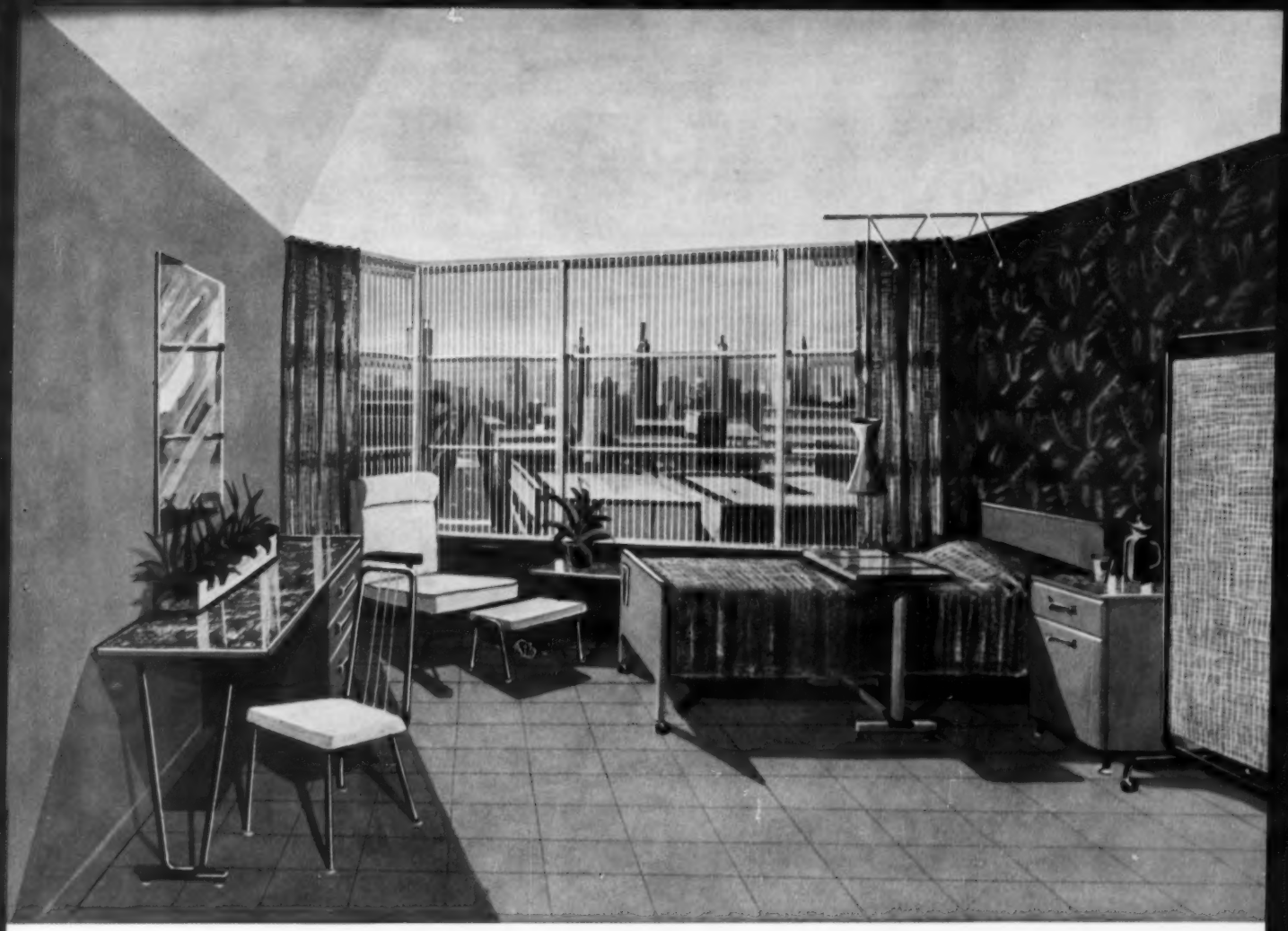
ALL MONEL CHAMBER CONSTRUCTION — lightweight Monel body heats faster . . . speeds process . . . saves time. Gives lifetime resistance against corrosive damage; eliminates rivets as potential leakage points.

No. 200 available for push-button **electromatic** or single control **manual** operation. Either unit converts instantly to manual Hi-Speed Sterilizer; automatic model runs manually in case of power failure.

WRITE TODAY for details on cabinet and recessed washer-sterilizers, and data on Castle sub-sterilizer room planning.

Castle LIGHTS and STERILIZERS

WILMOT CASTLE COMPANY 1700 E. Henrietta Rd., Rochester, N. Y.



No Dream ...this *Theme* hospital room by Simmons

But definitely practical in its concern for both patient and hospital staff. Every piece is the result of alert research, careful design, and Simmons' years of experience with, and appreciation of, modern hospital requirements. Created by the noted industrial designer, Mr. Raymond Spilman, *Theme* hospital furniture is constructed of sturdy, long-life metal that reduces maintenance to a minimum. Modular units permit efficient use of available space and an almost limitless variety of attractive arrangements.

In the room illustrated, furniture color is soft Heather Green. Desk-dresser is made up of modular basic three-drawer small case unit under a 58½" long top. Bedside Cabinet 30" high means greater patient comfort with the Single-Action Vari-Hite Hospital Bed. Textolite table tops, Naugahyde upholstery and famous Beautyrest mattress built especially for hospitals mean that comfort and beauty go hand-in-hand with durability. You'll find *Theme* costs are surprisingly moderate, too. It's the common-sense solution to building, modernizing, decorating problems.

Your Simmons agent or nearby Simmons office is always ready with advice based on nationwide hospital experience.

SIMMONS COMPANY

DISPLAY ROOMS:
Chicago, New York, San Francisco, Atlanta, Dallas, Columbus, Los Angeles

The most favorable prognosis depends on these four exclusive advantages of the

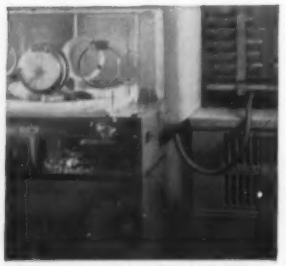
Isolette®

Infant Incubator

1. Controlled circulation of air: Maintains uniformity of humidity, warmth (and oxygen, if needed) to a degree impossible through convection alone. ISOLETTE hood need never be opened.

2. Precise temperature control within a tolerance of 1°F . . . with provisions for cooling as well as heating, and automatic alarm should outside factors cause overheating.

3. Positive humidity control through a single setting of a simple control valve. Constant, controlled recirculation maintains relative humidity at optimal level, as high as 85% to 100%.



4. Complete isolation: The individually air-conditioned ISOLETTE® uses fresh, outside air . . . protecting the infant from air-borne pathogens and droplet infection from the nursery!

Many infant incubators look like the ISOLETTE, cost less, but, in saving premature babies, or protecting the newborn . . . what really counts is performance, not resemblance. Send for copy of the objective, 22-page "Report of Comparison Tests on Infant Incubators," and review the well-documented "facts of life" in premature infant care.

Manufactured, sold and serviced by

AIR-SHIELDS, INC.

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"SAFE-WRAP" **MODESS® PADS**

Johnson & Johnson

Cost less than hospital hand wrapping

Get HEP

Hospital Economy Pack

FLEET® ENEMA

Disposable Unit

Including Lubricant

Hospital Economy Pack is especially designed for the budget-minded buyer. Each case contains 48 FLEET ENEMA Disposable Units packed in bulk with individually sealed rectal tubes. Handy... Economical... Practical.

When selecting a Disposable Unit, remember that only FLEET ENEMA is designed for easy one hand administration . . . saves nearly 28 minutes of attendant's time per enema. Only FLEET ENEMA Disposable Unit has an anatomically correct rectal tube patterned to minimize injury hazard and a built-in diaphragm to control flow, eliminate leakage.

Order "FLEET ENEMA, Hospital Economy Pack." If you prefer individually packaged units, then order "FLEET ENEMA Disposable Unit, Standard" . . . Your wholesale druggist or hospital supply house can furnish either.

33 ¾¢ ..... 4 doz.
32¢ ..... 12 doz.
30 5/8¢ ..... 24 doz.
30¢ ..... 48 doz.

HEP is supplied in *full cases only*

C. B. FLEET CO., INC.

Lynchburg, Virginia

Makers of Phospho® Soda (Fleet) gentle, prompt, thorough.

5-Hp. Unit serving three rooms.

Right: Municipal offices cooled with Frick Unit Conditioners

TRADE FRICK MARK®

Air Conditioning—

Packaged Units or Central Systems

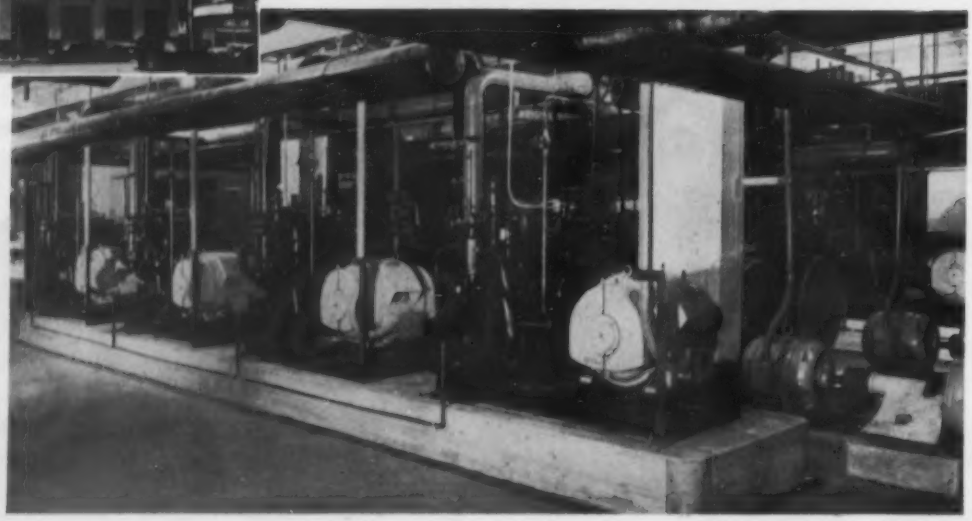
From a 3-hp. unit to a plant requiring thousands of tons of refrigeration is a long step, but they're both included in Frick-engineered air conditioning.

Built into Frick systems are 50 years' experience in air conditioning, nearly 75 in refrigeration, and over 100 in engineering. Nowhere else can you get this unique combination of experience and complete service. Ask for estimates today: write

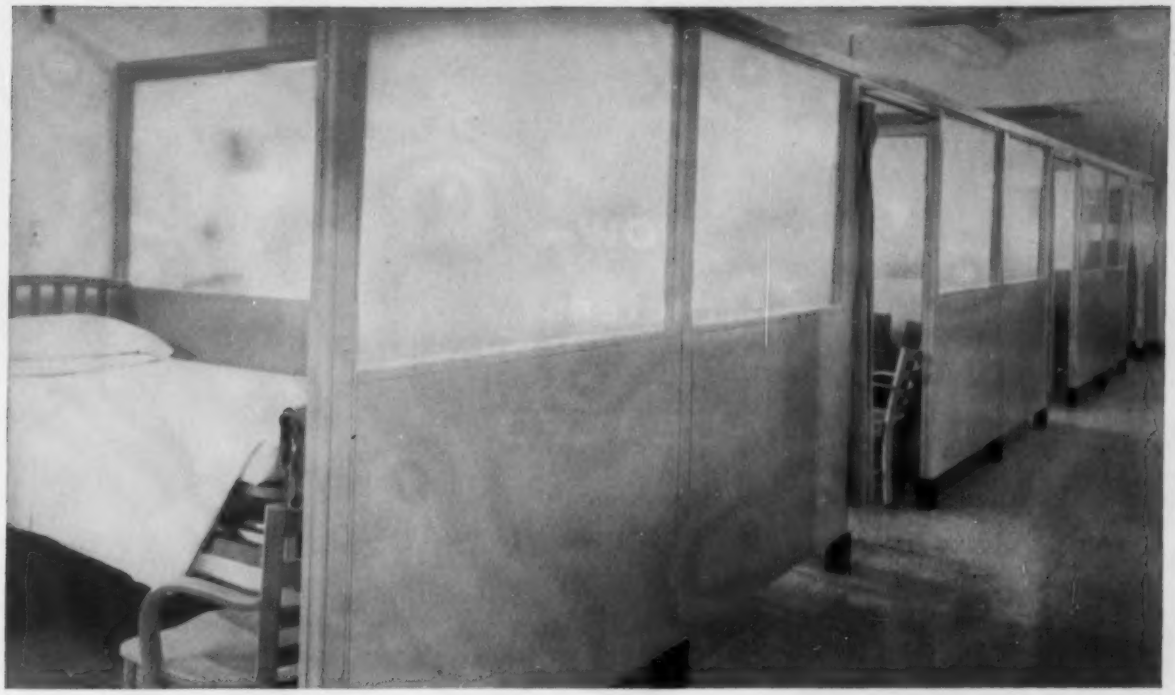
DEPENDABLE REFRIGERATION SINCE 1882

FRICK CO.

WAYNESBORO, PENNA. U.S.A.



The two 11-story buildings of the American National Insurance Co., at Galveston, are air conditioned by the multiplicity of 75-hp. "ECLIPSE" compressors shown at right. Thousands of fine buildings are Frick-equipped.



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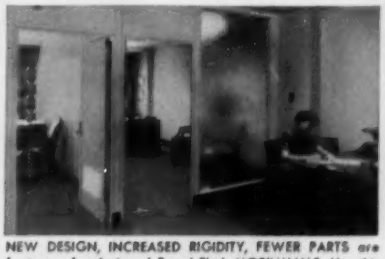

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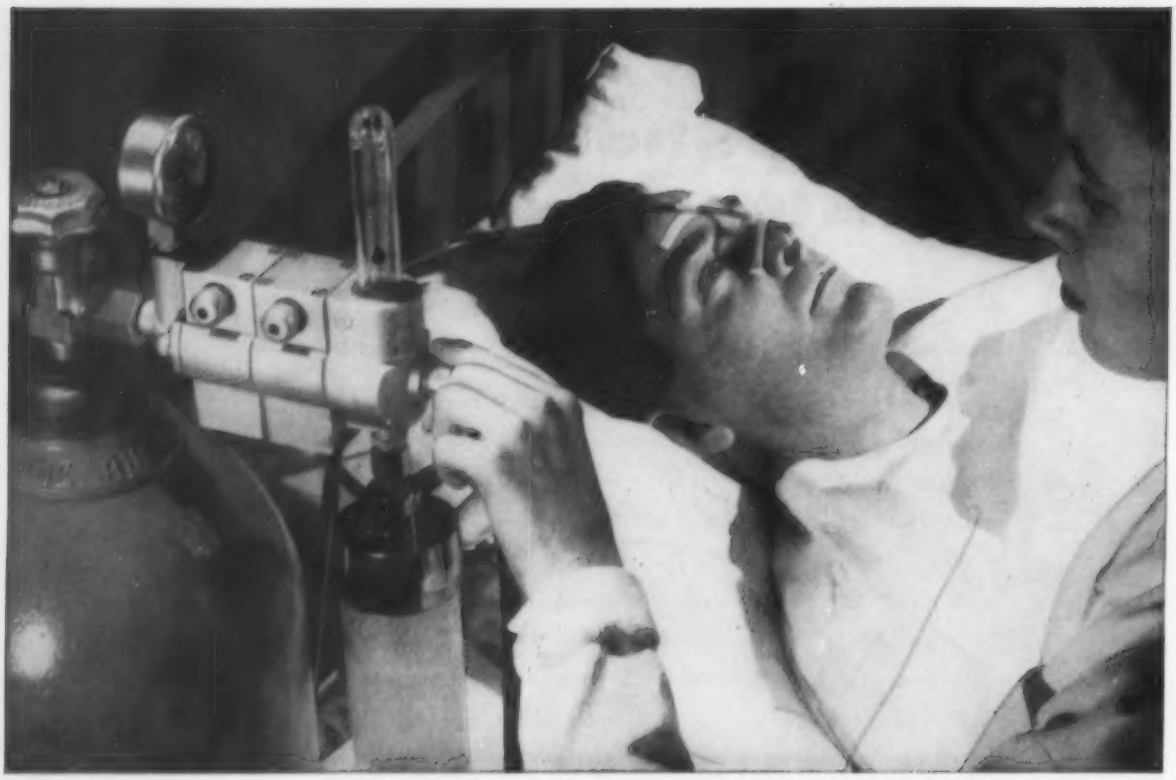

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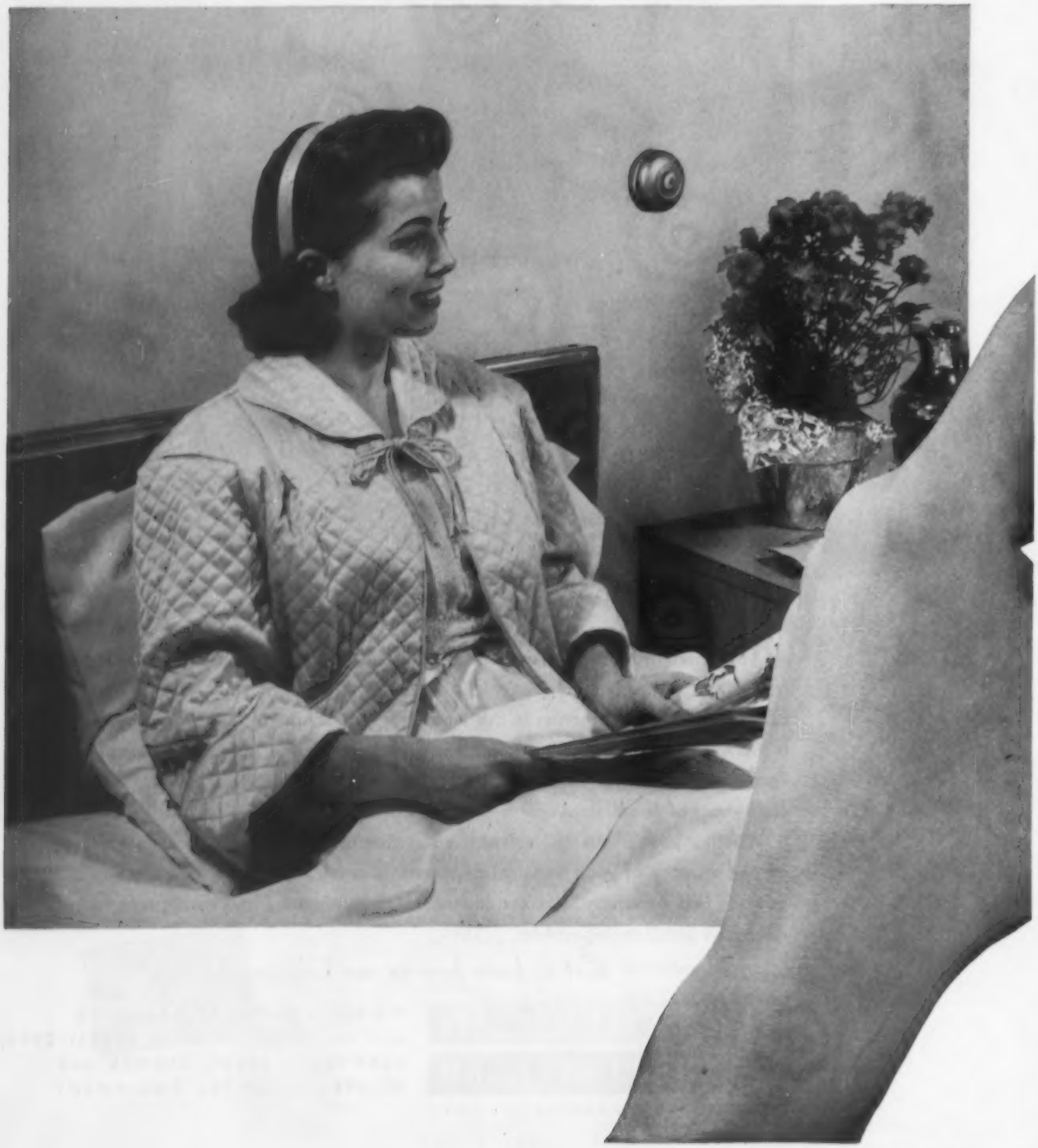

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The beautiful new Honeywell Round Thermostat is mounted for easy access by the patient. In 2-bed rooms it is mounted between the beds where temperature can be adjusted by either patient.

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Hospital Room Temperature Controls

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SMALL HOSPITAL QUESTIONS

Is "No Smoking" Enforceable?

Question: One of our doctors insists we should enforce the "no smoking" rule for patients and visitors, claiming that smoking is a definite fire hazard, as well as being injurious to health and a nuisance. We have taken the position that strict "no smoking" regulations could never be enforced, and the attempt to do so would only annoy patients and visitors and thus be poor practice from the standpoint of hospital public relations. What are the facts about fire and smoking practice in hospitals generally?—D.R., R.I.

ANSWER: The doctor is right about the fire hazard. Approximately one-fifth of all hospital fires reported are caused by carelessness of smokers. Except in areas where oxygen or other gases are being used, however, the "no smoking" rule is probably unenforceable, and attempts to banish all smoking would unquestionably result in some hard feelings, as you suggest. Most hospitals now permit smoking in patients' rooms, except when gases are in use, waiting rooms, dining areas and elsewhere where there is no functional hazard—and hope for the best.

Help With Job Survey

Question: We have never had any kind of formal job description or job classification program in our small (61 beds) hospital. Recent literature emphasizes the value of such programs. However, there is no one in our organization prepared or trained to make studies of this kind, and we hesitate to employ such a person, believing it is outside the limits of our budget. Is it appropriate in an organization of this size to employ someone to make such studies on a full-time basis?—C.L.C., Ill.

ANSWER: The value of precise job descriptions and a job classification program providing improved control over the qualification of personnel, salary schedules, advancement programs, training and other phases of personnel administration has been proved many times over. However, it may well be that in a small organization such as yours these values are established informally on a sound basis, so that formalized study by a personnel expert might have little to offer. We would suggest that you ask a well qualified personnel executive from one of the industries in your area to volunteer his services for a survey of personnel practices in the hospital to determine whether or not it would be economical to establish your personnel program on a more formal basis. Such "industrial aid" programs have been worked out successfully in a number of communities, and it is likely that through a member of your board of trustees or other community contact you can avail yourself of highly qualified personnel or industrial relations services that the hospital could not afford on its own staff.

No Grounds for Suit

Question: A former patient who was victimized by an "ambulance chasing" lawyer following the accident for which he was hospitalized is threatening to sue the hospital because the lawyer first contacted him when he was a patient here, and he claims the hospital should have protected his privacy. Does he have a case? As nearly as we can reconstruct what happened, the lawyer saw the patient in his room after stating at the front desk that he was a relative or close friend.—L.P.N., Mo.

ANSWER: This question was referred to legal counsel, who questions that the circumstances constitute ground for an action against the hospital, since the patient can show no harm done to him during his hospital stay, and the hospital apparently followed the usual practice of screening visitors and was not guilty of neglect. Of course, your attorney should be informed of all the facts right away, even though no lawsuit may actually be filed.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; A. A. Aita, San Antonio Community Hospital, Upland, Calif., Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Difference in Salaries

Question: I am trying to get our board of trustees to approve a general program of upgrading salaries for all classifications in the hospital, even if this means, as it certainly will, that we must raise rates. Board members acknowledge our salaries are low but resist any general increase, stating the view that we are a small hospital of 42 beds and shouldn't expect to pay the same salaries larger hospitals pay. Is it true that salaries for the same work classifications are generally higher in large than in small hospitals?—W.B.H., Wis.

ANSWER: Yes. In one state, for example, a recent salary survey shows average salaries paid some 30 different classifications increase consistently from the smaller to the larger hospital groups, with few exceptions. The figures do not indicate, however, that larger hospitals pay higher salaries because they are larger. It is likely that the salaries are higher because the larger hospitals tend to be located in cities, where salaries and living expenses are generally higher.

Cost of Laundering O.R. Linen

Question: In our laundry, we do surgical linen in a special bundle or run, separated from ordinary floor linen. (1) Is this a common practice? (2) Do hospital laundries ordinarily keep separate cost figures, showing how much more it costs to launder soiled linen from the operating room than linen from other departments? (3) How much more does it cost?—J.W.S., Ill.

ANSWER: (1) Yes. (2) No. (3) Calls to several well organized hospital laundries on this point brought out the fact that few if any keep costs separately, so the difference can only be estimated. Various estimates, made by experienced laundry managers, indicate that it probably costs from one-fourth to one-third more to launder operating room linen than it costs to launder the same number of pounds or comparable pieces of ordinary hospital linen.

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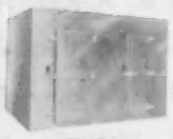

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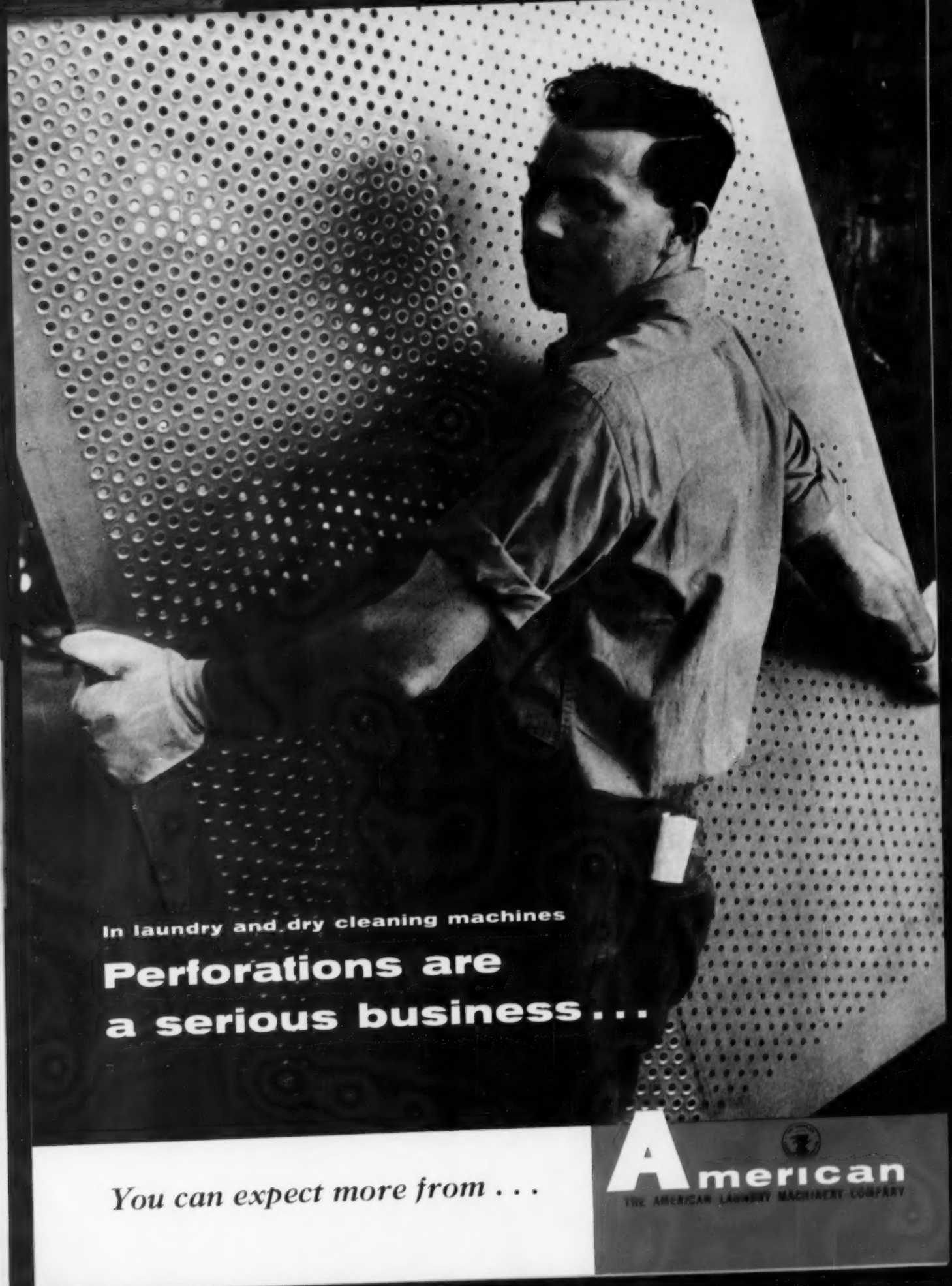
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Did you ever ask a machinery representative how big the holes are in the cylinder of a laundry or dry cleaning machine? Or how much distance between them? How many per square inch? Probably not—because that's one of the little things usually taken for granted.

Like every other important detail, hole size, spacing and location is a precise science at American. It depends upon machine capacity, kind of work to be handled, type of processing and amount of liquid or air circulation needed. In washers, for example, some of the factors that govern perforation size and spacing are buttons, cylinder diameter and number of compartments, and gauge of metal. Some perforations call for double embossing—a special process to give them a smooth inner surface and add strength to the cylinder. A washer, dry cleaning machine, extractor or drying tumbler? Each one is an entirely different story.

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TAX EXEMPTION

Hospitals worried that they do not qualify for Ford Foundation or other grants because of their tax status should keep in mind this directive from Internal Revenue Service: "An institution is not exempt merely because it is not organized for profit."

The I.R.S. ruling of April 30, 1956, describing requirements for tax exempt status, and which has caused so much concern among some hospitals, still is in effect and there is no plan for a reexamination or further interpretation.

If the hospital has a ruling from I.R.S. declaring that it qualifies as tax exempt, regardless of when the ruling was issued, it is still valid, according to tax officials, unless the hospital's status has been changed significantly. If the hospital does not have such a ruling, it would be wise for it to file an application for tax exempt status with the I.R.S. director for the district in which the hospital is located.

LITTLE OMNIBUS

States may get some federal dollars to help them train nurses and others in the health fields—or they may not. At this adjournment-rush stage the legislation is in a complete tangle. One bill has passed the House and another the Senate. That means a compromise to be worked out in conference committee. Given plenty of time that would be no problem—but there isn't plenty of time. Furthermore, once the bill is passed—if it is—an appropriation bill still will have to be voted by both houses.

Assuming the legislation passes, it will offer the states the following:

1. **Money to assist in paying training costs** for nurses, engineers, physicians and others in public health fields.

2. **Cash to help train graduate nurses** to qualify them for administrative or supervisory posts.

3. **Grants (through the U.S. Office of Education)** to help in the training of practical nurses and others at subprofessional levels.

4. **Grants for research in mental health technics** and to train personnel for work in mental health hospitals.

Except for the training of practical nurses, where $5 million annually is specified, all of these proposed programs are "open end." Year by year Congress will have to decide how much money can be used advantageously in these various fields.

This legislation, known as the "Little Omnibus Health Bill," is all that is left of the Eisenhower Omnibus Health Bill of last year. It was extracted from that bill, given a Democratic label, and started through Congress.

HILL-BURTON

The Hill-Burton hospital construction program is moving into its second decade not with money to burn, but with quite a bit to jingle. Furthermore, the "new" part of the program, which was almost two years in getting started, at last is well under way.

When the deadline came on use of the $21 million voted two years ago for the new program, the Division of Hospital and Health Facilities was able to report that almost $19 million had been obligated. Five months earlier when H-B officials had told Congress they expected to use up all but $3 million, appropriations committee members said that couldn't be done.

This is the last time H-B appropriations will have to be turned back to the treasury if not committed in two years. In the future all money can be held until used.

At the start of the present fiscal year on July 1 a total of 182 projects had been approved under the new H-B program, made up of 38 nursing homes, 42 rehabilitation centers, 38 chronic disease hospitals, and 64 diagnostic and treatment centers. Now every state and territory with the exception of the Virgin Islands have plans under way under the new program, and officials have no doubt that the $21 million just voted by Congress can be used.

The "regular" program has $102 million to work on, and $1.2 million has been voted for research. Although the legislation just got under the wire before adjournment, the Hill-Burton program has been extended another two years beyond its scheduled expiration date of June 30, 1957.

ALASKA MENTAL HEALTH

Alaska now will be allowed to take care of its own mental patients. The bill setting up a mental health program for the territory survived the bitterest and most incomprehensible attack of any health bill during the session. A group with some semblance of national organization in mid-session launched an attack on the bill's commitment procedures, claiming the result would be a "Siberia" for mental patients.

Although it was pointed out that the commitment machinery proposed was similar to that used successfully in many states, for a time the bill appeared to be lost.

Sen. Barry Goldwater (R.-Ariz.), a member of the committee that handled the measure, worked out a simple compromise: The commitment procedure was dropped out of the bill entirely, and the Alaskan legislature was authorized to decide how to commit patients without violating their civil rights. Although the legislature without much question will adopt a procedure similar to the one that aroused so much trouble, the Goldwater compromise worked like magic; the noise died down and the bill was enacted.

Under its terms Alaska will get $6.5 million from the federal government for use over a 10 year period to establish and maintain a mental health program, including inpatient and outpatient care. In addition, U.S. will turn over $6.5 million for construction of a hospital and other facilities for the mentally ill, and will receive a million acres of U.S. land, with the income from it to be used to support the program.

DISABILITY PAYMENTS

The year-long fight against payments for disability, led by the insurance industry, U.S. Chamber of Commerce and the American Medical Association, was lost in the Senate by two votes—47 to 45. The specific question was whether to add to the bill an amendment by Senator George which carried the disability payments program. Had the vote been tied, the amendment would have lost.

Assuming that the bill will not be vetoed—although the disability payments plan was opposed by the Eisenhower Administration—workers covered by O.A.S.I. will be eligible for full social security pensions at age 50 if they are certified as permanently and totally disabled. At the same time they will be referred to state agencies for rehabilitation, and their pension can be stopped if they break off rehabilitation for no good reason.

RESEARCH BILL

Hospitals involved in research, or willing to go into it, have some financial help in sight—federal grants to aid in building research facilities. A law authorizing the gifts was one of the few pieces of major health legislation to come out of Congress in the last frantic weeks.

This bill was a long time in becoming a law, and then just got through before adjournment. It was introduced at the start of Congress in 1955, sponsored by Senators Lister Hill (D.-Ala.) and Styles Bridges (R.-N.H.), each a power in his own party.

It was mid-July of last year before it passed the Senate. Another full year elapsed before the House took up the bill and approved it.

Under the program Congress will appropriate $30 million a year for three years, with the strong possibility, of course, that if all goes well there will be an extension. Money will go out in grants to medical schools, hospitals or clinics to construct buildings for medical research projects or to buy research equipment. Federal funds may supply no more than 50 per cent of the cost of any structure and its equipment.

Private as well as public institutions will be eligible, but they must be nonprofit.

MEDICAL SCHOOL AID

Not so fortunate was the bill for grants to medical schools. Because its sponsors feared it would be loaded down with the Powell antisegregation amendment in the House, and because of this amendment filibustered to death in the Senate, they held off until two weeks before adjournment. Then, instead of being reported out of committee, action that would attract attention, the medical school aid bill was offered as an amendment to the bill for research grants.

At first everything seemed in order. Although Rep. Adam Powell (D.-N.Y.) had insisted on a vote on his amendment on the regular (nonmedical) school aid bill (thereby killing the bill in the House), he did not press the amendment when Rep. Peter F. Mack (D.-Ill.) proposed to authorize construction money to medical schools as well as for research facilities.

The Powell amendment would deny grants to any tax supported schools that had not taken initial action to comply with the Supreme Court's antisegregation decision.

A few minutes before a vote was to be taken on the plan to give medical schools construction money for classrooms and teaching equipment, the claim was made that this was not germane to the research grants bill. The Speaker of the House agreed, and that was that. Again, as it has many times in the past, the medical school aid bill died. Efforts will be made next year, of course, to revive it.

JOINT BLOOD COUNCIL

The year-old Joint Blood Council apparently is not afraid to swim in troubled waters. The young organization, with headquarters in Washington, D.C., has about decided to ask both the commercial companies and Blue Cross to change their ways. Commercial carriers will be asked to limit their coverage to the cost of voluntary procurement, processing and dispensing of blood, and Blue Cross will be asked to drop donor payments and professional fees for blood, and to include the cost of processing and dispensing in its prepaid coverage.

In taking the step, the council's board of directors approved the action "in principle," but details are yet to be spelled out. Dr. Walter B. Martin, former president of the American Medical Association, was chairman of the committee whose proposal for reforms was approved.

In another area that may become at least as controversial, the board unanimously agreed it is "imperative" that minimal standards for accreditation of blood banks be decided upon. As of now there are no national standards for blood banks, nor is there any mechanism for accreditation.

In September the council will start a nationwide survey of blood banks and hospitals as the initial step in preparation of the first National Blood Banks Directory. It will give location; area served; how each is operated, organized and supervised; adaptability for expansion in a national emergency; volume of business and whether commercial or nonprofit, and relationship to allied services, such as tissue banks. The directory also will contain a glossary of terms and definitions used in blood banking and blood research.

FUNDS FOR PRIVATE HOSPITALS

Without legislation, which they have been unable to get, proprietary hospitals and nursing homes and private clinics now have an open door to a certain amount of federal financial help.

The Small Business Administration has changed its policy and now will make loans of under a quarter of a million dollars per facility to such institutions, if they are operated for profit.

The loans will be for a maximum of 10 years, and the interest rate may go to a top limit of 6 per cent. Direct S.B.A. loans will be made only if the sponsor's own investment equals the loan for a new building, or if the standing construction equals the requested expansion loan. If a bank shares in the loan, this participating requirement is not so exacting.

The Modern Hospital
AUGUST 1956

LOOKING AROUND

Boner Into Blessing

A FEW months ago, the American Hospital Association warned members that bids on the new headquarters building were out of line with estimates, and contracts were being held up while the association looked around for more money.

There wasn't any more, as it turned out, and last month the association told its members what had happened: Bids on the original building weren't just out of line, they were out of this world—by a staggering $3 million on a $4.8 million project.

The difference was attributed to the architect's low estimate, sharply rising costs during the planning period, and "the inflationary effect of the unprecedented volume of building activity"—a phrase that slips in and out of focus, like a bad television picture, sometimes appearing to mean something separate from sharply rising costs, and sometimes not.

However it came about, the building boner may have left the association and its members better off, on the whole, than they were before the burgeoning bids were opened. The decision to go ahead with the headquarters part of the building, lopping off the floors that were designated for the proposed Center of Hospital Affairs and the space that was going to be rented out to related organizations and activities, makes a virtue of necessity. The diminished plan, it seems to us, has several advantages over the original, taller version:

1. All the benefits of a new headquarters housed in an appropriate structure, with more than double the space of the present rabbit warren, are retained.

2. The total financial commitment is smaller than that originally contemplated for the building project. There will be no income from rentals, as had been anticipated, so a larger share of association funds may be used for building purposes right away. If this should mean some delay in the expansion of association services as outlined when the dues were increased in 1954, the members will probably contain themselves; the outcry for more rapid expansion has not been deafening.

3. The building will be so designed that expansion for hospital center activities will be possible at any time that additional funds for the purpose become available.

4. The misgivings of some members that the association might have a tendency to race its motor and expand to live up to its building plans can now be forgotten. The new headquarters should provide adequate space for existing and contemplated services; further expansion can then take place, as it should, in response to clear demands and needs of the membership.

While we can understand and sympathize with the disappointment that association officials must feel, as all of us do when our soaring dreams fail to materialize, we are inclined to the view that the entire contretemps will prove to be a blessing in wolf's clothing. Like a sensible man, the association is building a comfortable home for its family, with provision for adding rooms as they are needed. Only the very rich can build their mansions before the wedding.

Nurses' Worry

THE thing that worries nurses most, it is apparent when they get talking among themselves, is not low pay, or split shifts, or overwork, or the fact that they sometimes get pushed around and chewed up by doctors. More than anything else, they worry about having to do borderline medical procedures for which they are inadequately trained.

Not long ago, the Indiana State Nurses Association made a survey among its members aimed at determining the extent to which these practices existed. Of general duty nurses responding to the association's questionnaire, 35 per cent were giving intravenous solutions or medications, 23 per cent administered anesthetics to obstetrical patients, 30 per cent removed sutures, and 50 per cent gave intradermal tests or medications. Generally speaking, the percentages of head nurses, supervisors, instructors and private duty nurses performing

these procedures were about the same. Only about 200 nurses in these groups replied to the questionnaire, but, as an association official pointed out, the legal implications are grave if only 10 nurses are performing functions which border on medical practice.

An attorney for the association suggested that nurses giving intravenous solutions might be held liable if the work were not performed under direct supervision of a physician. Yet the questionnaire returns indicated 70 per cent of this work was done on "standing orders"—a term whose meaning is not always precise, but which certainly raises a question about the directness of supervision, if any.

Answering a query from another state, the law department of the American Medical Association said recently: "From a legal standpoint it appears that a nurse may perform intravenous therapy under the supervision or direction of a licensed physician. A nurse performing such therapy under the direction or supervision of a licensed physician would not be engaged in the practice of medicine and hence no criminal act would be involved. A nurse who performs a procedure for which she is not properly qualified or trained may incur civil liability on her part as well as those responsible for her actions. Consequently, only those nurses who are highly competent and well trained should be permitted to administer intravenous therapy.

"Fundamentally, if civil liability is to be avoided, neither the hospital nor the physician should presume a nurse to be qualified to administer intravenous therapy without making a specific determination of her qualifications, and no nurse who considers herself unqualified should undertake such duties."

Plainly, the hospital which permits nurses to perform medical procedures without direct supervision and without special training in the performance of these specific duties is on thin ice.

"Registered nurses are troubled regarding these practices they are called upon to do, which are often things for which they are not qualified," said the Indiana attorney. "A nurse is frequently expected by the physician in the hospital to do these things. There are two solutions for her—she may say, 'No,' that she is not qualified, but this is not a realistic answer. Therefore, the nurse needs training in these functions she is being asked to do."

Discussing the situation as it was revealed in Indiana, another attorney said, "If an R.N. steps into the field of medicine, that act alone does not make her liable if something unfortunate happens to the patient, if she does it as well as a physician would do under the circumstances."

Asked how one would judge whether or not an act has been performed satisfactorily, he had a lawyer's answer: "Submit it to a jury."

There must be an easier way—and there is: careful qualification, training and supervision of nurses who perform these borderline medical functions.

Which Is It?

A MAJOR objective of hospital planning today, in the opinion of Dr. Lowell T. Coggeshall, assistant secretary of Health, Education and Welfare, should be the creation of hospital facilities that comprehend the degree to which patients are disabled by their illnesses and injuries. "It is not necessary to have a patient in a $25 a day hospital room to have his gall bladder infection diagnosed or to recover from a broken bone," Dr. Coggeshall said recently. "A substantial proportion of hospital occupants could be moved at a moment's notice without danger to health or risk of life. Hospitals are personal service institutions with virtually each and every room equipped to give maximum service, whereas relatively few patients need such attention."

As Dr. Coggeshall has explained it, his idea would be to extend the recovery room concept in both directions, so that there would be a concentration of critically ill patients requiring careful medical supervision and intensive nursing care in one type of accommodation, and, at the other end of the scale, hotel accommodations for patients who could take care of themselves and still be available for observation or therapy.

"I believe a few specifically designed hospitals aimed at providing greater opportunities for self-service, attached to general hospitals, could well result in substantial savings to the hospitalized patient," Dr. Coggeshall concluded.

Actually, it shouldn't be necessary to build new hospitals to put Dr. Coggeshall's ideas into operation, at least in part. Starting tomorrow, any hospital that wanted to could concentrate its ambulatory patients in a single unit, or on a single floor, with possibly a nursing attendant or two to perform necessary clerical and observation functions. Food service to the floor could be discontinued, and patients sent to the central cafeteria for their meals. Housekeeping services could also be drastically reduced; one visit a day by a maid to make beds and tidy up should suffice.

Unquestionably, this unit or floor could be operated, and charged for, at a minimum rate — substantially less than the standard hospital accommodation. The screams of anguish would come from Dr. Big, who would be required to visit his patients in several parts of the hospital, instead of having them grouped conveniently, as at present, on a single unit or corridor. It would then be possible to determine whether the hospital is run for the convenience of doctors, as it sometimes appears, or to render needed service to patients at the lowest possible cost, as we frequently say.

Emergency Care

AS READERS of the "Modern Hospital of the Month" feature in the December 1954 issue of The MODERN HOSPITAL may remember, the Dallas County Hospital at Perry, Iowa, has a beautiful lobby flanked by one of those ceiling-to-floor glass panels that modern architects cherish. "It brings the outdoors right into the room," the designers say.

Not long ago, the glass wall at Dallas County Hospital brought in something else—a horse. Frightened by a barking dog, the horse ran up the hospital driveway and right through the glass wall into the looby. Stunned and bleeding, it fell to the floor. Surgeons on the hospital staff were busy with other patients, so police and veterinary aides were summoned. About 50 stitches were required, it was reported, and the patient recovered uneventfully—at another hospital.

How to Make Friends With Physicians

Although doctors should treat the hospital administrator with the same respect they demand, the administrator must assume the primary responsibility for creating harmonious relations

ROBERT A. ANDERSON

WHAT are the fundamentals of good relationships between the hospital administrator and staff physicians?

The question assumes more than ordinary importance because of the pressures with which the delicate balance of hospital-medical staff interests are currently beset. The great tide of change which has transferred the seat of *de facto* administrative authority from medical to lay control is still running. In the course of this adjustment, some of the "new managers" may have overstepped; some of the "dispossessed" have fought a bitter, rear-guard action. On the whole the trend has been for the best, reminding us that "good" relationships must be not only amicable, but also constructive.

SPUR TO PROGRESS

Of late, the hospital accreditation program, as a spur to progress, has here and there torn a flank. The revolt of the adjunct specialists has erupted, and will be felt more widely in the future. Such disturbances as these heighten the need for the man at the helm of the hospital to steer the wisest, surest course of which he is capable.

In the administrator-physician relationship, the strongest link is forged of the weakest material in any legalistic sense: free consent. It is not an understanding which can stand the repeated stress of imposed conditions. Such consent will result, in part, from the administrator's sincere recognition of the physician's legitimate aims. Among these are the freedom to prescribe; the presence of modern facilities and reliable personnel; the absence of improper competition from hospital departments; intelligent and considerate service for his patients, and privileges commensurate with his ability. These aims are not necessarily listed in order of importance.

Philosophically, the purpose of the hospital is to promote the public welfare by increasing the efficiency of medical practice. Although it selects those physicians whom it deems qualified to use its facilities, limits their fields, and promulgates certain rules for the safety of patients and the good order of the institution, the hospital should not unnecessarily limit the competent physician's freedom to prescribe. Full adherence to this principle occasionally will mean the relaxing of some time-honored regulation, the departure of certain employes from their fixed orbit, or the provision of some article which is foreign to the tidy stockroom catalog. It is necessary to remember that the patient, while submitted to certain mass routines, remains an individual whose physical and emotional makeup, diagnosis and particular needs never add up to precisely the same total as those of his neighbor.

Thus, the hospital may well have a rule which excludes mental patients or alcoholics. But these are generic terms, and the hospital must be concerned with the individual. In our own institution, we have frequently admitted patients from both classes, after conference with the physician, when it appeared that the patient could be helped and would not be endangering himself. Likewise, if the hospital can make visiting regulations, it can certainly suspend them for good reason; this has been done quite liberally in some instances when the physician recognized a real emotional need on the part of the patient.

Occasionally the carpenter shop becomes a clinical arm of the imaginative physician as it fashions some improvisation which he has prescribed to aid an orthopedic or a hemiplegic patient; such opportunities should be cheerfully received. Respecting the physician's freedom to prescribe also involves affording him the tools with which he can work best. The provision of a special instrument, a certain range or style of sutures, or a waterproof adhesive may run counter to the drive for standardization which exists in some quarters, but in most cases the effect on the total hospital economy is negligible.

DOES NOT MEAN CAPRICE

Only a narrow and largely discarded concept of efficiency would fail to adapt to such special requirements. To be sure, the freedom to prescribe does not extend to capricious demands which do not meet the test of common sense. The patient's medical needs must be distinguished from the doctor's personal whims. A coveted piece of equipment may have a cost far in excess of its value. But in general, while the practice of medicine remains an art and not an assembly line, the staff physician will resent red tape and penny-pinching limitations.

The administrator must be receptive

Mr. Anderson is superintendent of Wyoming County Community Hospital, Warsaw, N.Y.

"Resisting the march of progress is unseemly in the administrator"

to innovations in diagnostic and therapeutic procedures and the requirements they impose. The staff physician should be provided by the hospital with the improvements in scientific practice which have emerged from the experimental stage, as limited, of course, by the size and scope of the institution. The criterion for these accessories is not novelty but utility and the average physician is seeking, through them, not his personal gratification but better results in treating his patients.

STAFF PHYSICIANS REPORTED

At the Wyoming County Community Hospital, the selection of suitable equipment for premature infants posed a problem as various incubators and related devices appeared on the market. While the physical environment of the ordinary patient is largely an administrative matter, that of the premature newborn is primarily a medical concern. In view of this, the hospital in effect placed its resources for this purpose at the disposal of the responsible staff physicians. Their sifting of available reports resulted in a sound policy which was not based on the most numerous gadgets or the greatest cost. Given the opportunity to make use of innovations of merit, these physicians responded by bearing in mind the practical considerations of the hospital as well as the genuine needs of their patients. In similar vein, if radioactive materials, pulmonary ventilators or new forms of surgical dressing have demonstrated their value elsewhere, the administrator must be favorably disposed toward placing them in the hands of his own medical staff.

Of equal importance as an aid to the physician are competent nursing and technical employes who are given ample opportunities to keep pace with changes in their special fields. Resisting the march of progress is not seemly for an administrator, nor will it endear a man to his staff physicians. Indeed, the constant effort to close the gap between scientific developments and their application to his community is one of the finest aims of the administrator.

The technical services provided by the hospital should have the effect of supplementing the physician's office and assisting the employment of his skills, not of displacing them. The use of therapeutic technicians without qualified medical supervision not only competes with legitimate medical practice in some cases, but may have shallow or deleterious results in terms of patient care.

The observance of this principle proved helpful in getting a "physical therapy department" under way as a "department of physical medicine" at the Wyoming County Community Hospital. Whereas a highly skilled therapist was engaged to carry the department, it was felt that the greatest potential for constructive service in this expanding field lay in providing for active supervision of patient care by a physician with special training. As patients are received on referral only, the department does not compete with practitioners who offer certain modalities in their own offices. Professional consultation is facilitated, at no extra expense to patients, and active medical direction confers added prestige on the service.

While this is the accepted pattern in many places, particularly in the medical centers, smaller hospitals face the temptation of setting the therapist up in business largely unsupervised, in which event he or she will be, in fact, prescribing as well as administering treatment. Similarly the nurse anesthetist, oxygen therapist, orthopedic technician and other technical specialists are functioning in the realm of medical practice; they can contribute to the greatest degree as members of a closely knit team headed by a well qualified physician. They do not make the physician unnecessary. Correct referral policies that maintain the continuity of competent medical supervision are to the patient's advantage.

It must be emphasized, however, that the physician's province is not unlimited. Practitioners of medicine have no right to block the efforts of a community—or the hospital as a bulwark of the community—to improve the general health services. Routine chest x-rays, mass diabetes detection technics, courses for expectant parents, penicillin prophylaxis programs, health information services and other advances have passed, legitimately, into the public domain. Under correct auspices, they should not be withheld from the community just because some physicians regard them as a threat. It has been my fortunate experience to find the local medical profession receptive to such ideas, and helpful in implementing them, once they were appropriately presented to the medical society for consideration. But in any case the administrator, while seeking to uphold the interests of the physicians by way of reinforcing their value to society, must be wary when these interests become divergent from those of the public at large.

KEEP PHYSICIANS INFORMED

Although the administrator will make every effort to know the hospital's patients as well as time permits, the attending physician's relationship with his patient is a personal, almost a proprietary, one. Therefore whatever affects his patient's care, comfort, rights, pocketbook or attitude is a matter of importance to the doctor. Good service and considerate attention given the patient by the hospital organization will strengthen its prestige in the doctor's eyes. Conversely, any breach of the patient's interests will have its reaction, albeit unspoken, in the mind of the doctor. There is a concurrent obligation to keep the attending physician fully informed of administrative actions of consequence to the patient. All reports of accidents or unusual incidents should be routed through the physician. When a patient requests special privileges which cannot be granted, a prompt word to the physician will enlist his backing.

The staff physician has a right to privileges which are fully consistent with his abilities. Here the hospital board and its adviser, the administrator, sometimes find their rôle difficult. While individual physicians may resent the intrusion of new men as threats to their self-importance, if not to their income, staff members gen-

"The old school tie will be in evidence whenever physicians gather"

erally are often uncritical in the evaluation of qualifications. They may be quite openhanded where the element of competition is absent and good will is desired or needed. The hospital board and administrator must exert their influence as fully as possible in the direction of the greatest freedom of opportunity consistent with proper qualifications, desirable professional growth, and the safety and welfare of patients. It is a noble but often thankless course, for the physician who is grateful today may be resentful the day after tomorrow.

How "different" are physicians as a class? The human relations problems involved in the administrator's dealings with the staff are unlike those to be found in other fields but not necessarily more difficult. The peculiar parallelism of authority—medical and administrative—in the hospital is rendered tolerable by the intelligence of physicians as a class and the ability of the vast majority of them to see the ends which they share with the administration.

WANTS TO BE LEFT ALONE

The freedom from line authority, probably greater for the hospital doctor than for the member of any other type of organization, perpetuates the sense of independence which is learned in the long road upward and in the traditional pattern of individual enterprise which has always dominated the practice of medicine. In one amusing respect, at least, this independence is more fancied than real. Not a rare specimen is the busy practitioner who is literally surrounded by technical specialists, and still other hospital employes in depth; who finds at his fingertips, precisely at the moment he wants it, any equipment or supply item which he is likely to think of in a year of practice; to whose schedules a whole institution quietly conforms and whose every move is anticipated; who has been relieved, as if by magic, of every care which can qualitatively be delegated—and who occasionally is heard to observe, plaintively, that all he wants is to be left alone!

The administrator will find the "old school tie" somewhat in evidence whenever physicians gather. Although he is nonetheless welcome, unless he is himself a physician he cannot attain to the Hippocratic brotherhood whose rites of initiation are unique and indivisible. Nevertheless he can stand on his own feet as the representative of another, closely allied profession.

In practical terms, a certain group consciousness in physicians will alert him to a degree of discretion which he ought to exercise anyway. He will keep confidences to a minimum, particularly those of a derogatory nature, and not parrot the remarks of one physician concerning another. He will be wary of the physician who is a tale bearer and will remember that "who gossips to you will gossip of you." The administrator must be a friend to all, a partisan of none. He must constantly educate hospital personnel to avoid all mention or display of favoritism. Hardly any breach of conduct by nurses and other employes will so quickly make an enemy of the doctor.

It is well established that the average physician is a conservative; he clings to the even tenor of his ways and is apprehensive of change. The ultimate powers inherent in lay control of the hospital frighten him, when he thinks about them, and he tends to consider that governing board best which governs least. Moreover, he is impatient with the administrative details incumbent on members of a hospital staff today. Most such requirements have come about during his professional lifetime; they have had little or no place in his schooling, his basic concept of medical practice, or the conduct of his private office. There are notable exceptions to this unsystematic, unparliamentarian type, and for such exceptions every administrator is duly grateful. In general, he is well advised to hold administrative procedures to essentials, to predigest them whenever possible, and to avoid capricious changes in procedures. The effort to "streamline" such duties, however, must be carefully reconciled with the need for active self-government of the staff.

An administrator is a professional person in his own right. He disposes of his good judgment in the furtherance of an institution or trust; he has no other ware of enduring value. In the organization he occupies a unique position from which he sees all facets; his view of the whole may seem to blind him partially to the claims of any one segment. He wishes his detractors could observe a given situation from his vantage point, but he knows that, where he is, only one person can stand at a time. If he does not give his support completely to any person or group, it is because he labors, ultimately, for what he thinks is right: a composite ideal which does not precisely coincide with any one of them. Philosophically regarded, he serves no master but only a set of abstractions, which permeate his advice to his board, his directives to his personnel, his dealings with the medical staff, his service to the patient. Needless to say, they are not always correct, or he would have nothing to learn.

In any event, his training and conduct are professional and he is deserving of the same respect which he accords his staff physicians.

FORM OPINIONS CAUTIOUSLY

The administrator is cautious of forming opinions about the doctor's management of a case and shuns expressing them. He knows that Chance perches on the shoulder of every physician, that the physician manipulates no slide rule to an unerring result and purveys no slick article with a gilt-edge guarantee. The physician can simply apply his keenest, but imperfect, perception and his shrewdest, but imperfect, judgment. In a legitimate sense, the administrator "protects" the physician, according to the tradition of the medical profession itself and of hospital people.

When, in an administrative situation, the administrator has made a survey (workup) of all the factors involved, has had consultation (consultation) if indicated, has arrived at a conclusion (diagnosis) and has decided on a policy (course of treatment), he ought to be able to rely on staff physicians to respect his judgment—at least in public—as he would

"In terms of prestige, board membership would confer advantages"

respect theirs. Criticism of administrative decisions voiced promiscuously strikes at the confidence of the organization in the administrator, just as criticism of medical judgment, openly expressed, saps the confidence of patients in their doctor. Physicians should seek out the administrator with their complaints and in the meantime keep their own counsel.

Will this happy ideal take firmer root when hospital administration has attained greater maturity and identity as a profession? Perhaps so. Until that time, every administrator will find his path easier to the extent that he can cultivate a situation of *mutual* courtesy and respect in his own hospital. For the staff physician, loyalty is a small price to pay for the wholesale human effort which has produced his hospital and makes it function in a manner which he often takes for granted.

Is it superficial to say that the administrator needs *prestige* to help him in his relations with physicians? Of this intangible quality, he will bring some with him, he will be clothed with some when he arrives, and some—indeed a critical amount—he must earn. That which he brings into the situation derives from his previous attainments, his maturity, and the personality with which he happens to be endowed.

The hospital board, which entrusts its own objectives so completely to the administrator, can do much to confer on him an equivalent amount of recognition. To a great extent this will be determined by the light in which the trustees view his office. If they have tended to regard the administrator essentially as a business manager, while the fundamental ends of the hospital are either defaulted on or left to understandings directly arrived at by prominent trustees and staff physicians, it will not occur to them to pay him a salary which permits him to move easily among professional people. In driving a hard bargain with its candidate for administrator, the hospital board unwittingly reduces its own effectiveness.

The administrator is, in fact, the full-time representative of the board in all its wide responsibilities. He is the board's consultant as well as its chief executive. He must first formulate many of the policies which he later enforces. He must implement, through his knowledge of hospital affairs and his ability to interpret the board's intent, policies which are barely hinted at in any formal source of authority.

VOTE IS UNIMPORTANT

In the interest of reinforcing the administrator's office, therefore, his appointment as a member of the board is worthy of greater study than it has generally received. The fact that it would give the administrator a vote is unimportant, since any proposal dependent on a single ballot must be either ill-advised or ill prepared. In terms of prestige, however—a commodity of distinct value in medical staff relationships—board membership would confer definite advantages. It would add authority to his utterances and endow him with a degree of recognition which might otherwise take years to earn. It would tend to place him in proper relationship with respect to the various elements composing the hospital organization, so that he would appear less as an intermediary and more as an architect and spokesman of hospital policies at the highest level.

Greater consolidation of board and administration might also tend to allay any misconception of the board as simply one "side" in questions which interested persons will naturally regard from a different point of view. The treatment of other aspects of this type of structure is, of course, beyond the scope of this paper.

The administrator should promote the growth of true self-government of the medical staff in every way possible. Staff officers and committees develop only through use. To be sure, they should not be harassed with numerous petty problems. But the delegation to staff committees of certain decisions of some consequence, even when they could perhaps be dealt with by the administrator through informal consultation with a staff member, is a technic which tends to promote meaningful committee work. Selectively applied, it introduces physicians, to a much greater degree than otherwise, to administrative affairs. It recruits a body of intelligent, informed and resourceful persons to serve the ends of the hospital and it promotes teamwork. Medical record forms and standards, preoperative requirements, nursery practices, standardized drug lists, rules for consultation, and many other procedures could be worked out by the administrative staff functioning in a vacuum. But the physicians, not having been consulted about the play, could hardly be expected to run with the ball. New policies and procedures affecting medical staff which are arrived at through delegated authority may take longer; they also last longer.

Infractions of hospital rules by physicians are more effectively dealt with by other physicians than by the administrator. A reproof from a duly constituted staff officer or committee removes the irritant of "lay interference." The action taken is more likely to impress the offender and other staff members. For this process to have evolved into a useful medico-administrative tool, staff officers and committees must have begun to place the value of general good order and discipline ahead of a natural reluctance to admonish a colleague. They attain this degree of maturity by being formally charged with certain responsibilities in the bylaws and by being repeatedly expected to exercise them.

The hospital board should be counseled to avoid peremptory action in staff matters whenever there are established processes in the staff organization for dealing with them. Occasionally the board must remind itself that the word "ultimate" as applied to authority has in part the connotation of "final" or "last." Such authority should not be invoked precipitately since, as someone has well phrased it, "power is diminished when exercised." The board which is confident of its authority will delegate; the one which is uncertain or hostile will cling nervously to its powers and use them rashly.

A well informed medical staff is

likely to be more cooperative with the administration and better able to defend the hospital against unfair criticism. Doctors will feel more kindly toward nurse shortages and other problems if their objections can be acknowledged, if not anticipated, and if they realize that the hospital is working on a solution. When some untoward incident has occurred, involving a physician or his patient, the administrator does no harm in taking the initiative to offer his regrets and reassurances.

The regular presence of the administrator at meetings of the medical staff and certain of its committees offers the opportunity for disseminating pertinent information, although the privilege of the floor should not be abused. He may satisfactorily serve as secretary of the executive or other committees on invitation, thus establishing excellent liaison. Because of their scientific background, physicians are much better equipped to digest statistics than is the general public; this appetite can be judiciously fed at appropriate times. Certainly they should appear on the mailing list for key reports and literature of the hospital.

Staff physicians need regular opportunities to air their grievances appropriately. Friendly contacts established by the administrator offer the best single outlet. He should be a really good listener—sincerely interested, respectful of the physician's motives (most frequently based on patient satisfaction), and free of a defensive attitude. If the administrator finds that the physician is right, he should do something about the situation promptly, and afford the physician the satisfaction of a report after the matter has been attended to.

The "patient care committee," consisting of representative physicians, supervising nurses, and the administration (plus other executives or technical personnel in accordance with the agenda), provides another good outlet. It has the advantage of face-to-face contact with the person or persons best able to deal with a problem, or at least to illuminate it further for administrative action. As a group medium involving a certain degree of formality, this committee tends to discourage unworthy or ill founded complaints. It has many positive benefits, also, in the development of better patient care technics.

The joint conference committee serves as an outlet for medical staff problems of wider import, such as policies affecting privileges, the need for new services or capital improvements, medical association politics as they affect the hospital, and the like. The administrator should promote informal board-staff contacts as well, to the end of increased mutual understanding. Discussion of strictly administrative matters at this level is to be discouraged, however.

In summary, while there are many opportunities for discord in the complex field of administrator-medical staff relationships, the administrator himself must assume the principal responsibility for creating a harmonious and constructive atmosphere. As a team of observers* has perceptively commented, "The elements binding them together are more powerful than those dividing them."

*Burling, Temple, Lentz, Edith M., and Wilson, Robert, N.: The Give and Take in Hospitals. New York: G. P. Putnam's Sons. 1956.

New Commission to Continue Medical Statistical Program of Southwestern Michigan Council

CHICAGO. — Organization of the Commission on Professional and Hospital Activities, Inc., was announced last month by the American College of Surgeons, American Hospital Association, American College of Physicians, and the Southwestern Michigan Hospital Council.

The organizations established the commission to conduct a medical statistical service that will help hospitals simplify medical records and analyze records more effectively for improvement of medical and administrative practices, it was explained.

The commission has received a grant of $260,000 from the W. K. Kellogg Foundation, Battle Creek, Mich., to support the program for three years, after which it is expected the service may be continued on a self-sustaining basis.

Commenting on the new commission and its services, Dr. Paul R. Hawley, director of the American College of Surgeons, and president of the commission, said: "The principal objective of the new commission is to help hospitals and their medical staffs do a better job of caring for patients by the provision of accurate data and comparative analyses and studies relating to patient care."

By mechanizing the tabulation and indexing of hospital statistics, the program enables hospitals to obtain more complete and reliable data on patient care, Dr. Hawley added.

Members of the commission appointed by the participating organizations are: Dr. Paul R. Hawley and Dr. Robert S. Myers, assistant director, representing the American College of Surgeons; Dr. C. Wesley Eisele, director of postgraduate medical education, University of Colorado Medical School, Denver, and Dr. Eliot E. Foltz of Winnetka, Ill., representing the American College of Physicians; Dr. Edwin L. Crosby, director, and Maurice J. Norby, deputy director, representing the American Hospital Association, and C. Tiffany Loftus, director of Mercy Hospital, Benton Harbor, Mich., representing the Southwestern Michigan Hospital Council.

Representatives at large on the commission are: Rt. Rev. Msgr. Donald A. McGowan, director of the bureau of health and hospitals of the National Catholic Welfare Conference, Washington, D.C., and Dr. Luther C. Carpenter, a Grand Rapids, Mich., surgeon.

In addition to Dr. Hawley, other officers elected at an organization meeting here last month were Dr. Crosby, treasurer, and Dr. Vergil N. Slee, director of the Barry County Health Center at Hastings, Mich., secretary and director. The commission will establish its headquarters and conduct its services at Ann Arbor, Mich., it was reported.

The commission is an outgrowth of the Professional Activity Study carried on for the last three years by the Southwestern Michigan Hospital Council and directed by Dr. Slee, it was explained.*

"The work in Southwestern Michigan has demonstrated possibilities that the methods used there could be of significant help to hospitals," said

(*Continued on Page* 170)

*Myers, Robert S.: Hospital Statistics Don't Tell the Truth. Mod. Hosp. 83:53 (July) 1954.

Myers, Robert S., Slee, Vergil N., and Hoffmann, Robert G.: The Medical Audit. Mod. Hosp. 85:77 (September) 1955.

New Ideas for Efficient Operating Rooms

Little changes in equipment make a big difference in improving the effectiveness of the operating room team

JANET FITZWATER, R.N.

DRAMATIC advances in surgical technics in the last decade have created an increasing need for operating room nurses to be able to set up and assist in the operation of new and complex equipment, as well as to review and revise their own technics to keep pace with recent advances. Although there has been some progress in these areas, the development in recent years of several institutions devoted solely or largely to clinical research suggests that the rate of progress should now begin to increase materially.

The Clinical Center, which is an integral component of the National Institutes of Health, is a laboratory-hospital devoted wholly to clinical research. Nurses at the Clinical Center have had the time and the opportunity to develop some of their ideas to improve the quality of the services they give to patients and to the medical staff. In the operating room, because of the complex surgical procedures which were planned by the investigators, the need for designing new equipment or modifying even some of the most modern equipment soon became apparent. In fact, it was sometimes necessary to delay beginning some of the surgical research until these essential items of equipment could be fabricated. At the same time it was possible to incorporate changes which were recognized years ago as being an important factor in increasing the efficiency of the surgical team.

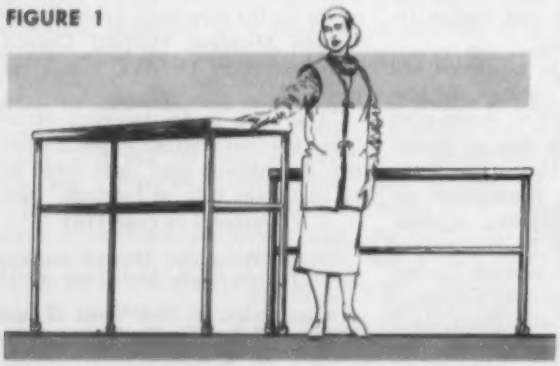
Following is a series of devices I have worked out which have proved to be of immeasurable value in improving the effectiveness of the surgical team.

Miss Fitzwater is chief, surgery nursing service, nursing department, the Clinical Center, National Institutes of Health, Public Health Service, Bethesda, Md.

HEIGHT OF OPERATING ROOM FURNITURE

Too frequently we see operating rooms equipped with tables and basin stands ranging in height from 32 to 34 inches. Past experience in equipping a new operating room revealed that operating room furniture was not commercially available in correct heights. Unfortunately, manufacturers of operating room furniture have not made modifications and improvements commensurate with discoveries in operating room technics.

FIGURE 1



For many years we have been cognizant of the fact that the floor in the operating room is one of the greatest sources of contamination and we have conscientiously discarded materials dropped below waistline level, but we have done little in the past really to resolve this problem. However, the problem can be resolved quite simply by modifying equipment. A table or stand 32 to 34 inches high will be approximately 8 to 10 inches below the waistline of the scrub nurse standing on the floor. When the position of the patient necessitates the use of footstools, the discrepancy becomes even greater. In order to overcome this existing problem it is necessary to raise equipment from 8 to 10 inches for most surgical procedures, and from 14 to 16 inches for a few specialized procedures. This can be accomplished by adding hollow steel tubes of the correct height to equipment which is too low.

Figure 1 shows a table before and after modification in relation to the height of the nurse.

FIGURE 2

STERILE VESTS

Along this same line of needed improvements which, when accomplished, will provide greater safety for the patient and improve the quality of nursing service, we can introduce the use of the sterile vest. The problem of unsterile backs has existed since the beginning of sterile technic, but little has been done to ensure greater safety. Today, because of the increasing complexity of surgical procedures, necessitating the use of more equipment and a greater number of employes, the need to eliminate this problem becomes even greater.

New types of equipment and an increase in the amount and size of equipment are needed for intricate surgical procedures. In order that equipment can be placed where it will be accessible to all members of the operating team, it is paramount that the backs of the operating team be sterile. The proximity of necessary equipment and the elimination of a possible source of contamination ensures safety of the patient and provides greater efficiency. The vest pictured in Figure 2 is inexpensive to make, easy to don, and allows freedom of motion.

FIGURE 3

SUCTION ASSEMBLY

Another type of apparatus commonly used in operating rooms that needs improvement is the suction unit. Since it is desirable in many situations to make a quick and reasonably accurate estimate of blood loss during surgery, it is necessary to provide some means by which this can be accomplished.

The suction assembly pictured in Figure 3 was designed and constructed to meet this need. It is a calibrated glass cylinder which is secured in a weighted wooden stand by means of a slot. It is marked in 25 cc. amounts and has a capacity of 2000 cc. The tall narrow cylinder enables one quickly and accurately to estimate the blood loss. The height of the stand places the bottle at a desirable level for reading. The weighted stand built with a slot to accommodate the octagonal foot piece on the cylinder prevents breakage or tipping of the bottle. The cylinder is easy to empty and clean, and the entire assembly is simple and inexpensive to construct.

DRAINAGE BOTTLE HOLDERS

Because of the large number of patients who must leave the operating room with various types of drainage tubes inserted, we are confronted with the problem of safely transporting patients to the nursing units with the drainage bottles connected. In turn, the nursing units face the hazards of placing drainage bottles on the floor beside the patient's bed.

To eliminate these the metal bracket shown in Figure 4 was designed. This bottle holder hooks over the rail of the stretcher while the patient is transported, and later is hooked over the bedside rail parallel with the position where the tube is inserted. This holder prevents breakage and overturning of the bottle and places the bottle at a more desirable level for observation of contents. It further provides safety and comfort for the patient by reducing the tension on the tube (Figure 5). The permanent metal hook can be replaced with an adaptable clamp to facilitate wider usage.

IMPROVED EQUIPMENT AND TECHNICS FOR THORACIC AND PELVIC SURGERY

The increasing trend toward specialization makes it appropriate that equipment corresponding with the particular type of surgery be provided. Standard operating room equipment is not constructed to meet the needs brought about by increasingly complicated thoracic and radical pelvic surgery. In an endeavor to solve some of the many problems peculiar to this type of surgery, new equipment has been designed and fabricated.

(Continued on the Next Page)

FIGURE 4

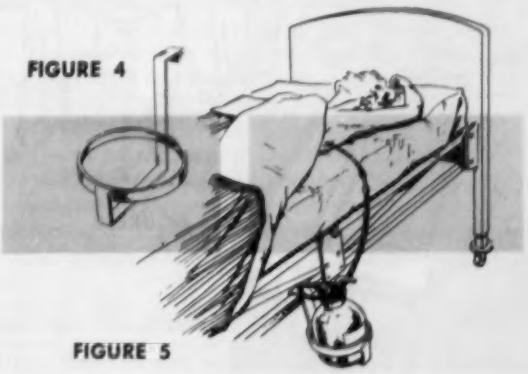


FIGURE 5

THORACIC INSTRUMENT STAND

The standard instrument stand provided commercially is inadequate for thoracic surgery. This inadequacy results chiefly from the size and instability of the stand. A need for a larger and more stable stand resulted in designing and constructing the instrument stand pictured in Figure 6. The stand is constructed of stainless steel. Conductive casters are equipped with locking devices. Raising and lowering the stand is easily accomplished by rotating the handle which projects from one side. The top metal frame accommodates two standard size instrument trays placed in vertical position. The 6 inch gap between the trays is covered with sterile plastic film and is used for emergency drugs and medications, thus making it possible to separate these items from the instruments.

The stand is wheeled over the foot of the operating table and locked in position before the patient is prepared and draped. Sterile draping of the stand is continuous with the chest sheet. Sterile trays of instruments are set up on standard instrument stands and transferred immediately following the draping. This new stand provides adequate space for the great number of instruments used in thoracic surgery.

Adequate space and stability are also provided for large instruments, such as the rib spreader, rib cutter, and rongeur. The stand is situated so that continuous intravenous fluids could be given into the feet and legs of the patient, and the anesthetist can work freely beneath the sterile drapes if necessary. It has further increased the efficiency of the operating team by placing equipment within immediate reach of the scrub nurse, surgeon and assistants.

FIGURE 6

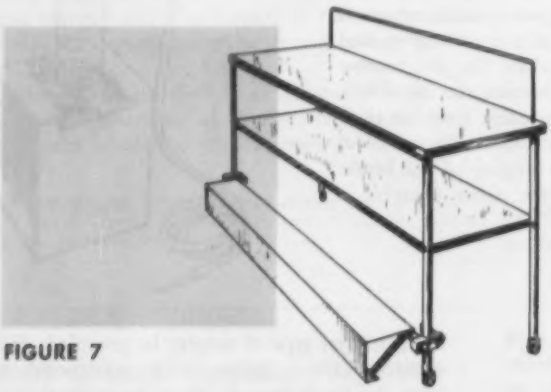


FIGURE 7

RESERVE INSTRUMENT TABLE

Also included in our revised setup for thoracic surgery is the modified reserve instrument table. The table pictured in Figure 7 is a modification of a commercial table 32 inches high, 60 inches long, and 24 inches wide. The table was raised 14 inches in order to place all equipment contained thereon at waistline level to parallel the lateral position of the patient. A foot stand 12 inches wide and 8 inches high was attached by a bar which permits turning the foot piece back when the table is being moved or not in use. This stand provides a stationary platform for the scrub nurse which enables her to retain the same position constantly throughout the procedure. A rail ¼ inch in diameter and 8 inches high was extended across the back of the table in order that large instruments could be safely placed near the back edge.

The complete setup for thoracic surgery is shown in Figure 8.

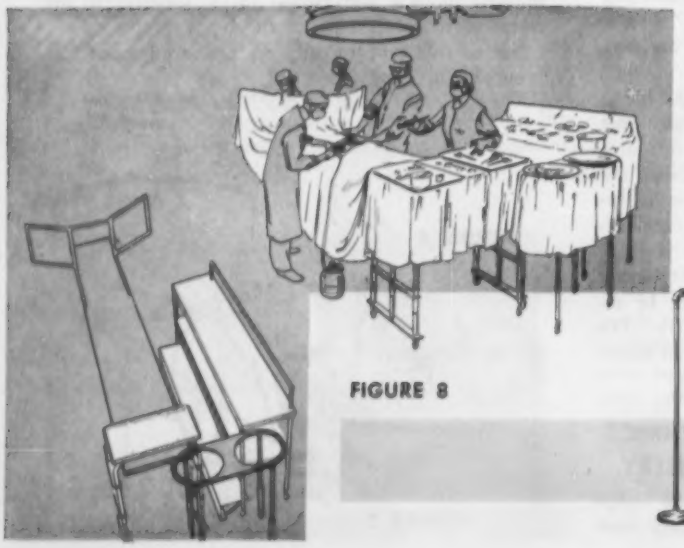


FIGURE 8

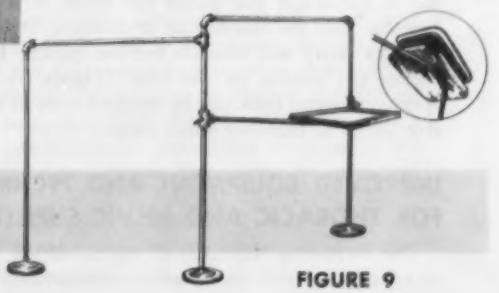


FIGURE 9

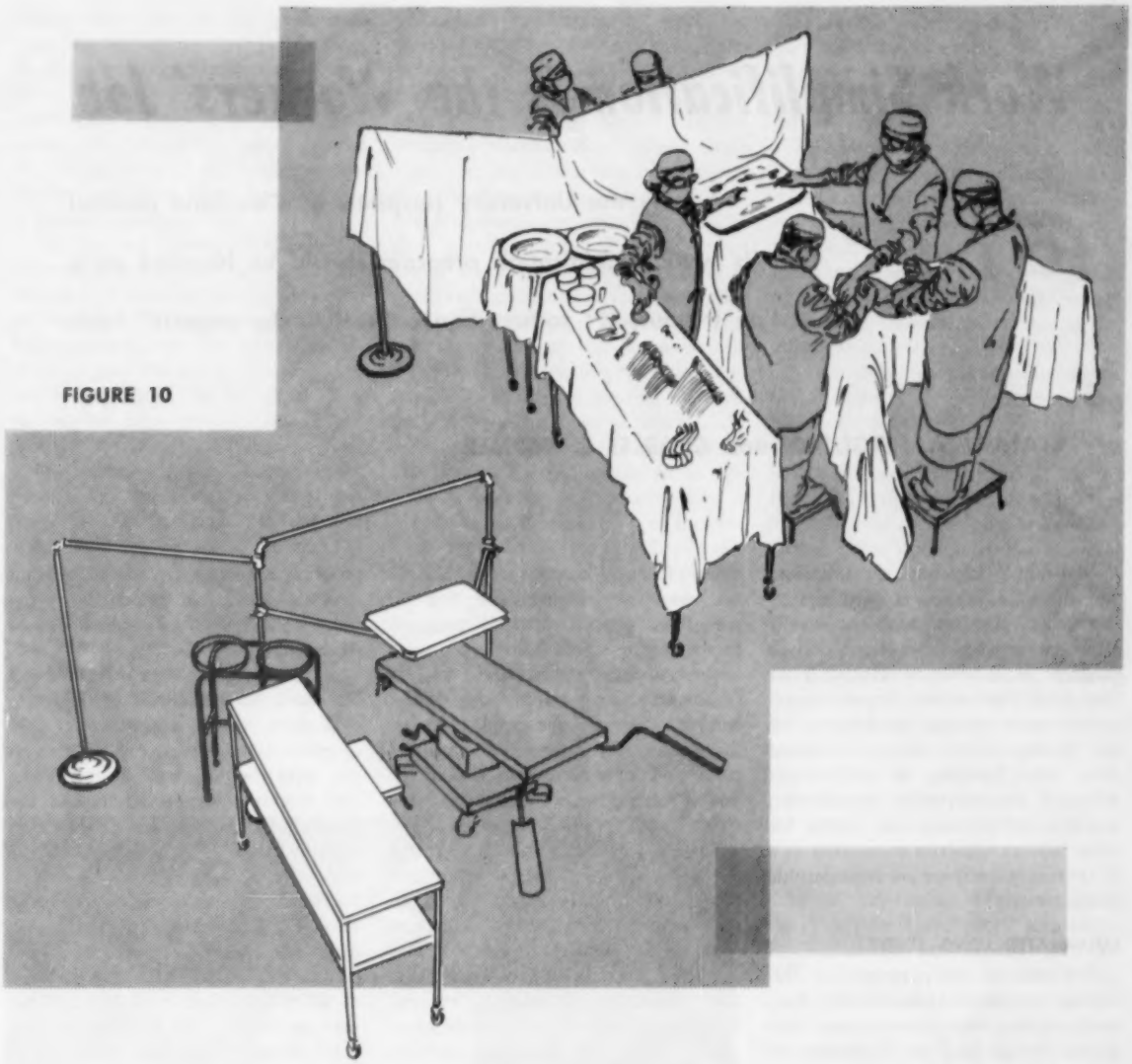


FIGURE 10

COMBINATION PELVIC SCREEN AND INSTRUMENT STAND

Radical cancer surgery presented problems similar to those encountered in thoracic surgery. One of the problems was a lack of sufficient space for an instrument stand when a two-team approach necessitating a combination lithotomy and supine position is used. The instrument stand must be placed in a position where it will be accessible to all members of the operating team and enable the scrub nurse to render competent assistance.

The combination screen and stand illustrated in Figure 9 was constructed to meet this problem. The frame is made of chrome plated hollow metal tubes. The foot pieces are weighted to prevent tilting. One side of the frame swings to and fro to permit any kind of arrangement of sterile equipment. An instrument tray is attached to the screen by two diagonal bars and can be adjusted to any desirable height. The stand is positioned at the head of the table before the patient is prepared and draped. Draping is accomplished by two flat sheets of double thickness and a continuation of the laparotomy sheet. Sterile instruments are set up on a standard instrument tray and are transferred to the stand immediately after draping.

This combination screen and stand increases efficiency by placing instruments in an accessible position to all members of the surgical team. When the tray is suspended from above, it is possible for all persons involved to have access to the instruments and the operating table without getting in one another's way.

The height of the frame shields the sterile instruments and basin from unsterile anesthesia equipment and provides a safe area in which the anesthetist can move freely. Figure 10 shows the complete setup for pelvic surgery with the combined positions being used.

The author wishes to express sincere appreciation to the instrument section and art department of the National Institutes of Health for their valuable assistance.

Work Simplification Is the Workers' Job

Why the University Hospitals of Cleveland decided that its work simplification program should be handled on a "do it yourself" rather than a "call in the experts" basis

STANLEY A. FERGUSON and CHARLES B. WOMER

GREATLY improved attitudes and teamwork, as well as improvement of specific operations, are early results of the work simplification program in progress at University Hospitals of Cleveland. Operational improvements already made include simplification of the writing and ordering of special diets, faster handling of medical records for the outpatient department, and the use of simplified forms for x-ray reports which have resulted in a 25 per cent increase in stenographic productivity.

CULMINATED LONG STUDY

The start of the program last November was the culmination of a long study of methods improvement programs being used in hospitals and industry. The work simplification program chosen is a dynamic, evolutionary one based upon the philosophy of Allan H. Mogensen, a noted consultant who coined the term "work simplification" in the early 1930's. Although only our department heads and administrative staff have participated in the program to date, we anticipate that work simplification will rapidly become a way of life at University Hospitals.

The investigations which led to our work simplification program were not undertaken in the belief that we were doing a poor job in methods improvement. On the contrary, we thought we were doing a good one; but we recognized that a planned program might help us to do better. We were impressed with the apparent success of organized programs in industry, and believed that with the rapidly increasing community attention to hospital costs and operations we should be doubly certain we were making every effort possible to do a better job.

Our early investigation of organized programs disclosed that there are two basic approaches to planned methods improvement. The first and most prevalent is the "expert approach." This is carried out either by employing outside consultants, or having "experts" on an organization's staff who are given responsibility for initiating methods improvements in that organization.

The second approach might be called the "do it yourself" approach. This is the one in which responsibility for improvement is vested in the line organization, with the people therein being trained in the tools and technics of improving their operations.

After a careful appraisal of both types of program we decided that any planned program in our hospital should be based upon the "do it yourself" approach. There were several reasons for this decision:

1. The administration of University Hospitals has traditionally felt that improvement is one of the most important responsibilities of our supervisory employes. These people have accepted this responsibility and many times have demonstrated their ability to improve their operations. We feared that the use of the "expert approach" to a program might create the impression in their minds that responsibility for improvement was being taken out of their hands.

2. In a large and complex hospital like ours, no person or small group of persons, such as administrative staff or methods engineers, can be conversant with the details of all operations. The working out of details and the handling of many intricate human relationships have to be widely delegated. We thought a well planned "do it yourself" program would be extremely valuable in developing the management and supervisory skills of our people, thus enabling them more easily to solve both their technical and human problems. We believed an "expert" oriented program would be of little value in this extremely important area.

STAFF IMPLEMENTS CHANGE

3. An "expert," whether an outside consultant or a staff member, can only recommend change; the line organization has to implement it. The gap between a good recommendation and its implementation is usually a human one. A look at the experience of both hospitals and industry demonstrates that difficult human relations problems often arise when an attempt is made to implement proposals initiated by "experts." Deterioration of human relations many times results because these problems are not fully recognized and successfully solved.

4. We believe that the personal service activities of our hospital, such as the nursing care of patients, offer as many, or greater, opportunities for

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This is the first of a series of articles on the work simplification program at the University Hospitals of Cleveland. The second article will appear in the September issue of this magazine.

Mr. Ferguson is director and Mr. Womer is assistant to the director, University Hospitals of Cleveland.

improvement as do the production activities such as food preparation and laundry operation. These personal services and their human organization are often quite mysterious to the "expert." Thus, they are many times ignored by him in favor of the hospital's production activities when he works in a hospital situation.

We do not intend to convey the impression that we believe the "expert" cannot be a valuable asset to a hospital methods improvement program. We believe that he can. A "do it yourself" program and the use of "experts" are not incompatible. In fact, many organizations have found that such a program creates an environment most conducive to the effective use of expert services. It opens the minds of the people so that they readily accept, and often seek, an "expert's" counsel in solving difficult problems.

Having decided on a basic approach to organized methods improvement, we next studied the question of how to go about it. During the course of our investigation of planned programs we learned of a most successful work simplification program, based upon the philosophy of Mr. Mogensen, that was being carried on at the Cleveland Electric Illuminating Company, a privately owned public utility which furnishes electrical power to northeastern Ohio.

Several discussions with officials of that company greatly impressed us with Mr. Mogensen's approach. We thought that if such a program could be so highly successful in a public utility it could be successfully adapted to a hospital. This belief was based upon the fact that many of the operations of a public utility are more nearly comparable to those of a hospital than are the operations of most industries. At the Illuminating Company the program had produced good results when applied to these similar operations.

Following our expression of interest in the type of program they had developed, officials of the Illuminating Company made arrangements for our management group to meet with Mr. Mogensen to discuss his program and philosophy further.

The term "work simplification" means many things to many people. To some it is an efficiency drive or cost reduction program. To others it is merely a suggestion system, or having industrial engineers on an organization's staff.

Mr. Mogensen defines work simplification as the "organized use of common sense to find easier and better ways of doing work." It is based upon a consultative approach by management and supervisors, the development of a spirit of understanding, participation and cooperation on the part of all of the people involved.

Work simplification is a philosophy, not a science. It is something that has to be developed over a period of time. It is not something that can be bought, used and discarded. Results in work simplification depend upon the attitudes of the people involved far more than upon particular technical skills.

Mr. Mogensen cites three factors which govern intelligent action in solving problems and improving methods: First, there must be a desire; second, the people must have the ability, and third, and most important, they must have the capacity for handling the human relations involved.

Desire has to be created. Some of the things that make people desire to improve are recognition, the sense of participation, and being part of a team or movement. Most organizations with successful work simplification programs use slogans such as "Work Smarter, Not Harder," and other promotional devices to create and maintain a desire for improvement on the part of their employes. A work simplification program, to be successful, must be carried on in an atmosphere where people have the incentive to use their brains to the best of their ability.

Do most people have sufficient ability to apply work simplification to their areas of activity? James F. Lincoln, head of the Lincoln Electric Company, says, "Great as American industry is, it leaves largely untapped its greatest resource, the productive power, initiative, and intelligence latent in every person."

The third factor governing intelligent action in problem solving and methods improvement is the one that requires the most attention. Much has been said in the past about the handling of human relations problems and the need for a better understanding of human relations by supervisory and management people. Mr. Mogensen

The use of a continuous type of x-ray report form eliminates most of the preparatory and finishing steps connected with the typing of the traditional multiple copy form. This work simplification improvement increased the efficiency of stenographers approximately 25 per cent.

believes that most of it has been made far too complicated.

As far as work simplification is concerned, he believes it is relatively simple. "We must recognize the existence of two outstanding traits of human nature: It is human nature to resist change and to resent criticism." Work simplification, of course, involves change and change often implies criticism. Managers and supervisors must understand why this resistance to change and resentment of criticism occur and be able to overcome them.

Mr. Mogensen feels that these negative traits of pepole can be most easily overcome through the use of the consultative approach. If it is used wisely there will be little or no resistance to change. Because it is their idea, or because they play an important rôle in its development, they will usually devote every effort to see that it works. Also, if the change is a person's own idea, or if he fully understands its necessity or desirability, he is not going to resent the criticism that would be implied if someone just told him to change his way of doing things. He won't feel he is being criticized. In fact, often he will want to tell everybody how poorly he was doing the job before and how well he is doing it now.

We recalled recent situations in our own hospital which proved to us the validity of the consultative approach. In one, the complete rebuilding of our labor and delivery floor, we were faced with the problem of maintaining full services in an area while remodeling it. The reconstruction would have to be done in sections and would take a year to complete. We could see no way of doing it without imposing many inconveniences on our patients, personnel and physicians.

Because of these problems we decided to bring all personnel and physicians concerned in on the planning of the project. Proposed layouts and schedules were posted on bulletin boards on the floor and were discussed in meetings. Suggestions for improvements were solicited from all concerned.

As a result of the use of this approach the plans for the project were greatly improved through the incorporation of many of the suggestions that were made. Also, the noise and "organized confusion" accompanying the remodeling have not brought a single complaint from personnel, physicians or patients. We are convinced that just the time saved by not having to listen to complaints has more than offset the extra time that it took to consult with these people on the planning of the project.

In another situation we did not have such fortunate results. A new area, replacing an older and smaller one, was completely planned by the top supervisory people concerned. The people who were going to work in the area would only have to move in and enjoy their improved working conditions, increased space, and the labor and time saving devices and procedures that had been installed for their use. Upon moving, they did appreciate their better working conditions and increased space, but wanted no part of some of the labor and time saving mechanisms. Each of the inevitable "bugs" that develop when new systems and procedures are installed become another reason why they were no good and could not possibly do the job. It took almost a year to persuade the workers to use some of the devices in the manner intended!

LET DEPARTMENT HEADS DECIDE

Our next move, following our meeting with Mr. Mogensen, was to send a member of our management group to his work simplification conference at Lake Placid, N.Y. This person was to evaluate further the applicability of a work simplification program to a hospital and assume administrative responsibility for the early development and guidance of our program should we decide to start one. Following his enthusiastic report we were convinced that we should develop a program. We decided to introduce work simplification to our department heads, however, and let them make the final decision.

Our year of study and discussion had convinced our management group that a work simplification program would be our best approach to organized methods improvement. It seemed to us that such a program is especially suited to a complex human organization like the hospital. We realized that it is not an easy approach, but we believed we could plan a program that would result not only in improved methods, but in better human relations, higher morale, improved teamwork, and management and supervisory development.

We believed we had the two basic prerequisites for a successful program: full management support and a proper "climate" in our organization. Without these, our chances of developing a successful program would have been greatly diminished.

We now had to instill in our department heads the same enthusiasm for the program that we had. How this was done, and how we started our program will be the subject of another article.

New Method Speeds Performance Rate of Routine Blood Tests, Researchers Report

NEW YORK. — A new method that triples the rate of performance for routine blood determinations was reported recently by research workers on the staff of the Sloan-Kettering Institute, a unit of Memorial Center for Cancer and Allied Diseases here.

Vernon T. Riley and W. C. Valles told the American Physiological Society the method has proved useful in studies of 10,000 patient blood samples for determination of sedimentation rates and hematocrits.

These procedures are used in routine screening for anemias, allergies, many acute and chronic infections, and a variety of organic disorders.

Under the new method, the determinations are made in the same test tubes in which the blood is collected from the patient, saving the time and equipment previously used to prepare blood samples in special, calibrated small-bore tubes.

Readings are made by holding the tube against a specially prepared proportional volume scale, it was explained.

According to the investigators, sedimentation rates or hematocrits can be run on several hundred patients a day by one technician, compared with less than 100 tests by previous methods. The two methods are comparable in accuracy, they reported.

Additional advantages reported by the investigators are that no handling of the blood is necessary, eliminating any possibility of infection, and sampling errors resulting from improper mixing or measuring of blood are eliminated.

THE MODERN HOSPITAL OF THE MONTH

Main entrance and lobby of the new Gratiot Community Hospital. A shop for visitors and patients is located just off the lobby.

This Hospital Can Grow Without Pain

When the time comes, expansion of Gratiot Community Hospital from 86 beds to 125 can be accomplished without interruption of service

OUTLINE OF CONSTRUCTION COSTS

Total cost, including Group 1 equipment (approx.)		**$1,000,000.00**
No. of beds	**86**	
Cost per bed		**10,663.00**
Total square feet	**48,691**	
Square feet per bed	**540**	
Cost per square foot		**18.03**
Total cubic content	**469,883**	
Cubic feet per bed	**6,102**	
Cost per cubic foot		**1.70**

MORE than the usual careful planing" is shown in the design of Gratiot Community Hospital, Alma, Mich., according to its director, Ralph C. Hutchins, who became head of the hospital some months after it was opened.*

Probably the outstanding feature, to which both Mr. Hutchins and Architect Clark R. Ackley of Lansing, Mich., point with pride is the low cost of $18.03 per square foot, which is said

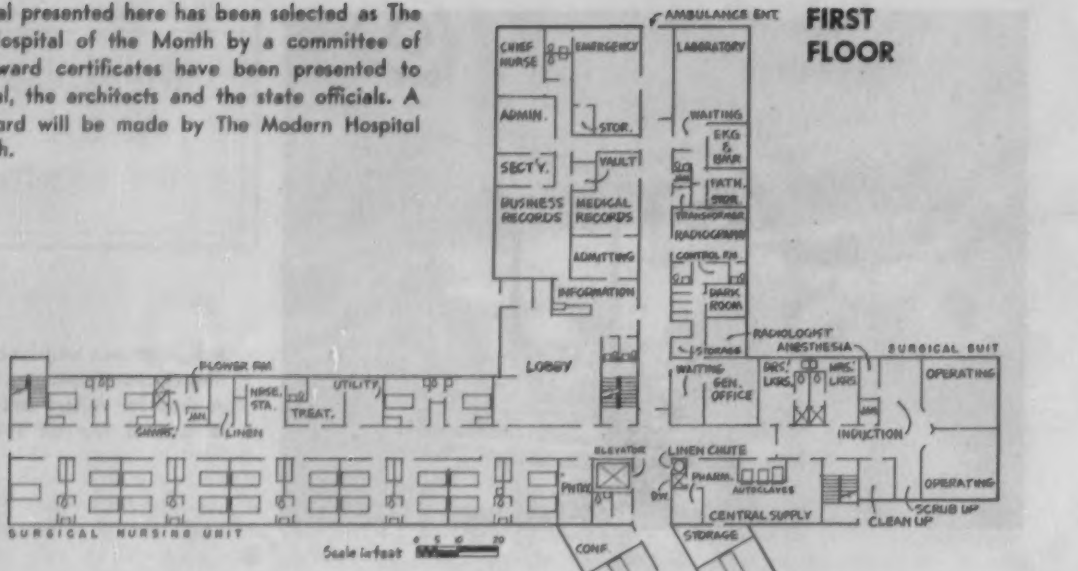
(*Continued on Page 65*)

*Succeeding Arthur R. Allaben.

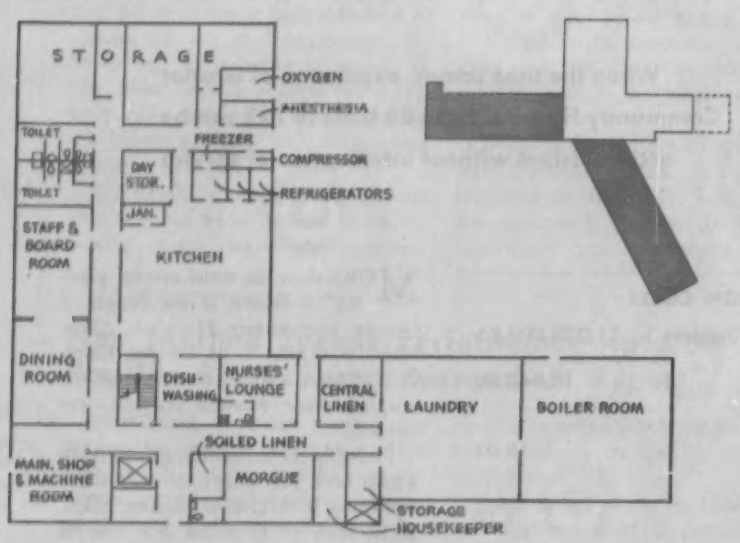
General view of the Gratiot Community Hospital, showing the ambulance entrance, which is located close to the laboratory and x-ray services.

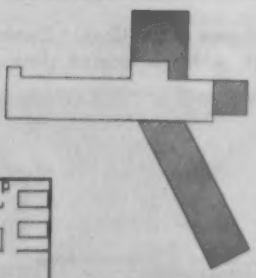
The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects and the state officials. A similar award will be made by The Modern Hospital each month.

FIRST FLOOR



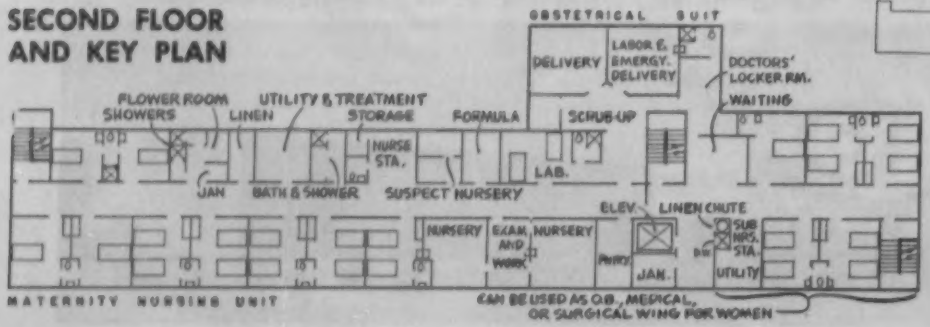
BASEMENT AND KEY PLAN





UNSHADED PORTIONS OF KEY PLANS ARE THE AREAS SHOWN IN BASEMENT AND 2d FLOOR PLANS

SECOND FLOOR AND KEY PLAN



Above, left: One of the two nurses' stations (one on the medical and one on the surgical unit) with chart rack, narcotics cabinet and sink alongside of the nurses' desk. Above, right: The laboratory is directly across the hall from the emergency entrance and is readily accessible to outpatients. Right: The compact, built-in locker and drawer combination stores the patients' personal effects tidily and also provides space for flowers.

(*Continued From Page 63*)

to make Gratiot one of the lowest cost hospitals in the state. This reduction in cost Mr. Ackley attributes, at least in part, to the use of monolithic concrete floor and ceiling construction.

The "unusually careful" planning resulted in some other advantages that should be of interest to all administrators, Mr. Hutchins reports, among them the main entrance, the emergency entrance, the location of the medical records and central sterile supply departments, the isolation nursery, and isolation suite.

DESIGNED FOR 125 BEDS

All central services are designed to take care of 125 beds. The original plans allow for expansion through the addition of a second floor on the southeast wing (above the medical and pediatrics units), and all of the usual provisions have been made for expansion of future rooms and maintenance shops in the uncompleted area on the ground floor of this wing. Hence, it will be possible to add needed beds without interrupting existing services.

The layout of the entrance lobby affords excellent control of visitors and gives outpatients convenient access to x-ray and laboratory facilities. The admitting office and cashier's window were placed so that they would be accessible but private.

EMERGENCY AREA ACCESSIBLE

Thought was given to the placement of the emergency entrance, which instead of being hidden away from everything, as is often the case, is close to the laboratories and x-ray department.

Another strategic bit of planning, in Mr. Hutchins' view, was the location of the medical records room. It is adjacent to the admitting office and also close to the emergency entrance which is used by the members of the medical staff who are thus within hailing distance of the record librarian when she needs to talk to them.

The central supply area is situated so that nursing personnel in the surgical department can perform the joint duties required in surgery and central supply; duplication of personnel is thereby eliminated. The incorporation of the drug room and dumb-waiter in this area has also added much to the efficiency with which it is operated, it was explained.

The obstetrical department can care for from 14 to 24 patients and there are 18 bassinets. In addition to the spacious well-baby nursery, ample provisions have been made for an isolation nursery.

TWO ROOMS FOR ISOLATION

The isolation suite of two private rooms, each with private bath, is equipped with detention screens.

The layout of the entire hospital, Mr. Hutchins concludes, affords a complete and workable separation of the various services that is remarkable in a small hospital.

Sorting for the monthly summary. A complete set of requisitions contained in two trays is shown being sorted for summarization and posting to the permanent inventory file at left.

Traveling Requisition Controls Stores

A new requisition form offers a useful method of determining stock consumption and keeps the employes conscious of the cost of the items they use

JOHN C. BARKER

CONTROL of general stores is a troublesome problem in many hospitals. In the very small hospitals where inventory is limited and the use centers are few, sufficient control for practical purposes can be exercised by the administrator or his delegate through a simple record system. Importance of proper control increases rapidly, however, with the size and complexity of hospital organization, and the degree of control to be exercised must be determined by evaluating the cost of the control program in relation to savings effected.

Our hospital with a bed capacity of 340 beds is limited in storage facilities and carries an average general stores inventory of about $22,000, excluding linen and one or two other items which are easily segregated and accounted for by specific control. The general stores inventory turns over about eight times a year, accounting for consumption of some $150,000, or 7 per cent of the total expense budget. While the amount of $22,000 is probably too small—in relation to such other assets as accounts receivable of 10 times that amount—to warrant much audit attention from a balance sheet point of view, and does not compare in importance with the inventory in a manufacturing or selling enterprise, the high rate of turnover makes it a sensitive area of control in a hospital.

Mr. Barker is assistant director, Maine General Hospital, Portland, Maine.

STORES ARE CASH

For all practical purposes stores are the equivalent of cash. They are expendable, and are guarded carefully. Perhaps the only reason they are not proved to an independent count every month as cash is reconciled to a bank statement is that a prohibitive amount of work is involved. In control problems of this nature we usually resort to inspection of consumption data in lieu of frequent stock tallies but, here again, unless accurate consumption data are readily available, the task becomes a burdensome chore and seldom is carried out completely enough to ensure against waste and other loss.

Under our old system the conventional multiple item requisition form was used. Each nursing floor or other use center submitted its requirements to the storeroom on this form, often listing a dozen or more different items. After filling and delivering orders the storekeeper was left at the end of each day with the arduous task of pricing each item on every requisition, coding it to the proper departmental expense account, and analyzing all requisitions to obtain the total issue of like items for posting to his permanent inventory cards. Requisitions were then forwarded to the accounting office where they were hand-sorted by departmental and expense classification codes and

totaled for inclusion in the monthly operating expense figures. This method, in addition to being cumbersome and detailed, gave total consumption figures only and little or no information or control of departmental use by individual items.

The basic idea behind our desire for an improved system was to obtain stock consumption history with a minimum effort and in sufficient detail to identify item consumption by cost centers or use locations. With more than 70 such cost centers in the hospital to consider and more than 800 different items available to each center from the stores inventory, our controller and purchasing agent set about devising a system which would accomplish the desired results. Having seen the basic application of the "traveling requisition" reported in a national magazine and learning that a few hospitals had already successfully adopted the procedure, they finally evolved a modified system suited to our own individual problem.

The new requisition form is a 3¼ by 7½ inch stiff punch card of the same type used by many hospitals for gathering statistical information. Individual cards for each item carried in the stores inventory are prestenciled by addressing plate in one corner with the item description, unit price and a code number which combines identity of the item with the expense classification to which it will be charged. In the other top corner is stenciled the name and code number of the department that will issue the requisition, all numbers being also prepunched into the sorting code which borders the edge of the card. Each department or use station is then provided with a set of cards made up of one for each item customarily consumed.

STORES CLERK FILLS ORDER

When ready to order from the storeroom, the department selects from its box the several individual requisition cards for items wanted, enters the date and quantity needed, binds the selected requisitions in a fitted ring cover, and sends them to the storeroom. The stores clerk fills the order, check-marks the requisition against each item delivered, and returns the complete ring cover to the department with the delivery. His work is then complete; unit pricing and account coding have been previously stenciled on each card, while price extensions and quantity consumption will be figured later on a total monthly basis for costing to department expense and credit to inventory.

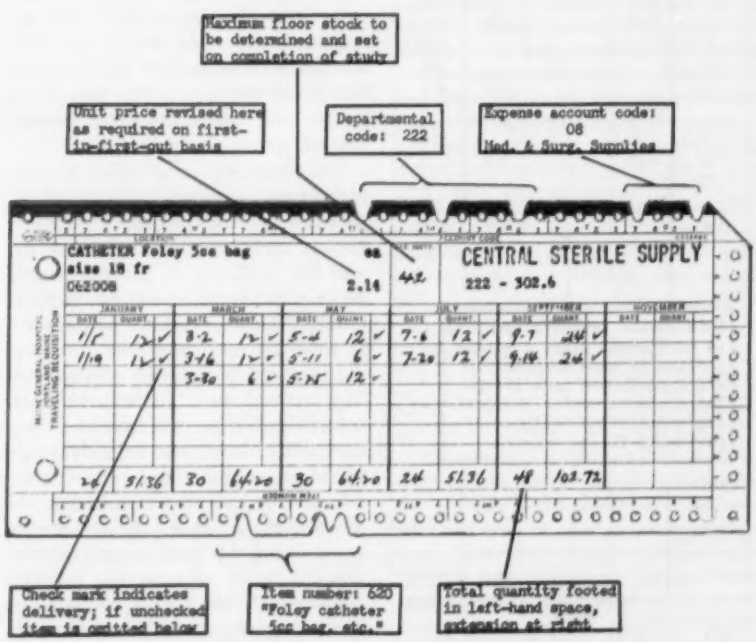
Two complete sets of requisitions are required. Each requisition card is designed for use during six alternate months. The use center keeps its original set of requisitions for one month, adding each new order to the withdrawal record and resubmitting in the ring cover to the storeroom as supplies are required. At the end of the first month, the second set covering the alternate six months' period is issued while the first is picked up for accounting cost distribution and control study. Alternately, one set is in circulation while the other is being analyzed.

A total of about 10,000 cards per year, or 5000 in each set, is required for a hospital of our size. Original preparation of these cards when the system is first installed presents a real project but, once this is accomplished, yearly preparation of the new requisitions becomes a simple stenciling routine. As new items are added to stores, new requisition cards are prepared and added to the existing sets of such centers as will require them.

At the end of the month when each departmental set is picked up and the alternate set is issued, the cards arrive at the purchasing office arranged numerically by item number and by department but in mixed order with regard to expense classification. They are then mechanically sorted by means of the border punched coding device into numerical sequence, thereby accumulating all like items together and eliminating departmental grouping. The purchasing agent now checks unit prices for each item to determine that it is reasonably close to the historically average price on a first-in-first-out basis, completes by adding machine the monthly consumption of each item, and makes a single posting of the total monthly withdrawal to the perpetual inventory record, which is kept in his office rather than in the storeroom.

The inventory record card supplements the traveling requisition by showing the complete history of each purchase, partial delivery, monthly total issue by quantity and cost, as well as all pertinent source data such as vendor's name, price and order point. One of many important advantages to the purchasing agent is the rapidity with which he can determine

MAINE GENERAL HOSPITAL TRAVELING REQUISITION



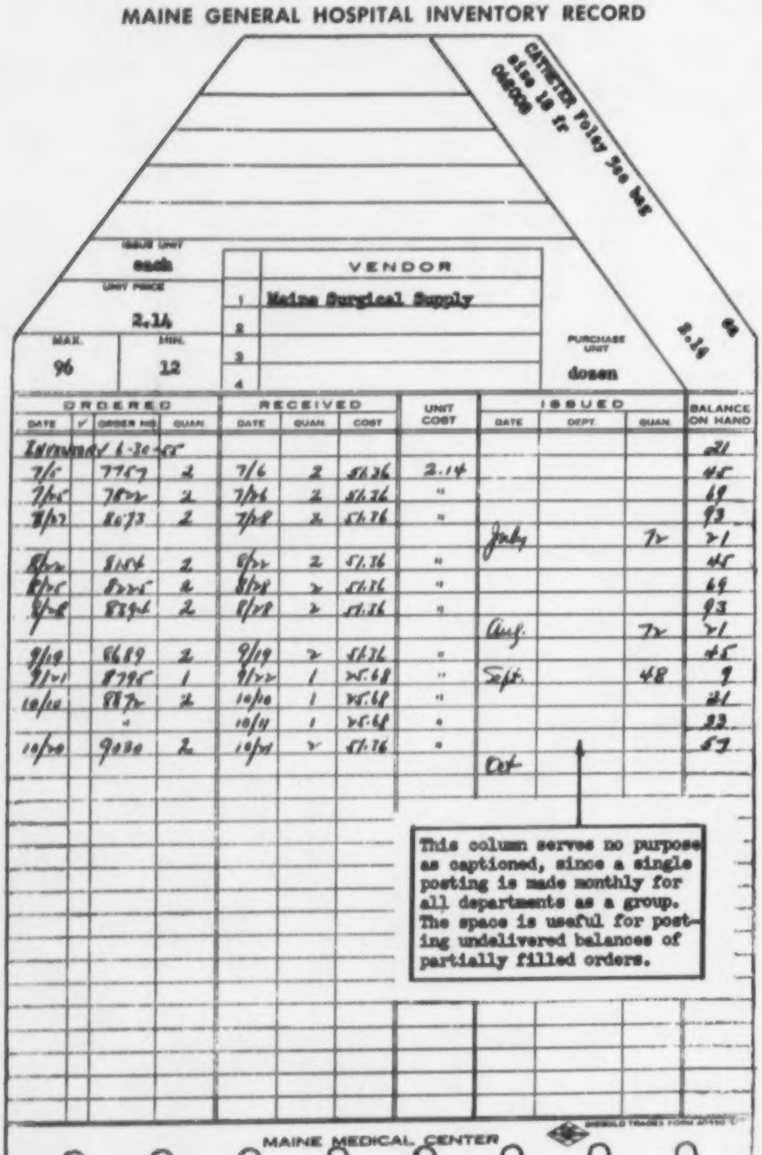
Two complete sets of requisitions are required. Each requisition card is designed for use during six alternate months. In a hospital the size of Maine General Hospital (340 beds), a total of about 10,000 is required.

whether or not an order has already been placed for an item which is reported by the storeroom to be in short supply without the necessity of hunting through the order file. The records in the storeroom have been eliminated; reliance is placed on the storekeeper's alertness for notifying the purchasing agent of short supply items, and occasional spot checks plus semiannual physical inventory keep the records in accurate balance.

Finally, the purchasing office foots and extends the prices on all requisitions, resorts them into departmental grouping subdivided by expense classifications rather than by item number sequence, and transmits them to the accounting office which simply takes an adding machine tape on the groupings required to compile single monthly entries to departmental expense accounts. The cards are then returned to the purchasing agent for resorting to the original item number sequence under departmental grouping ready for redistributing to the use centers at the beginning of the next month.

Advantages of the traveling requisition have come up to our expectations and few of the disadvantages which we anticipated have been realized. Our greatest fear—that individual requisition cards would be lost—has proved groundless and, although in one or two instances cards did disappear temporarily, misplacement rather than loss was found to be the answer. We are working on a refinement of the system which will eliminate this risk.

MAINE GENERAL HOSPITAL INVENTORY RECORD



The inventory record card supplements the requisition by showing the complete history of each purchase, partial delivery, monthly total issue by quantity and cost, as well as all of the pertinent source data.

ACCOUNTING OFFICE IS HAPPY

Estimates of timesaving have been realized. While it is true that elimination of record keeping in the storeroom has placed an additional load on the purchasing office, the latter is better equipped for this type of work and the fact that we are dealing in totals rather than in multiple single items saves in the over-all time involved. Although the several sorting procedures sound formidable, the sorting device provided by the manufacturer reduces this operation to a simple mechanical routine. The storeroom workers at first complained that they were slowed down in filling orders but with increasing experience they have now regained their original speed and enthusiastically agree that the elimination of pricing and coding multiple items on individual requisitions amounts to a saving in time and effort of at least one day a week. The accounting office was happy to trade one-half hour on each of 25 days for a single four-hour period in extending prices and assembling the posting journal.

The monthly journal, which is completed on a comparative monthly basis, provides data for the quick determination of card loss, clerical inaccuracies, and the localizing of use fluctuation. From this journal it will be possible, after sufficient experience is recorded, to establish maximum and minimum departmental inventories, thus controlling loss and waste. Individual departments also become cost conscious when comparing their own monthly usage as shown on the requisitions. Future benefits include the availability of more nearly accurate forecasts of total supply needs by item, thereby making possible more advantageous contract price negotiations for larger deliveries or for drop shipments if storage capacity is limited. The combination of these benefits leads us to believe that we have found a useful control tool for an important area of expense.

Nurse Education Costs Less Than You Think

Administrators who bewail the "vast sums" they spend to educate nurses will be surprised to learn from this report how little they really pay in comparison with what they get

BERNARD J. LACHNER

FOR a long time, most of us have been figuring our costs for operating a school of nursing on the average cost. As a result of using this method, a good many people have become alarmed over the staggering amount that this educational activity has added to the hospital budget. Recent studies on this basis have shown that average cost per student per year range in the neighborhood of from $600 to $1500, which includes adjustment for the tuition the student has paid to the school and the dollar value of the services performed by the student nurse.

There are two major considerations in a study of this type. The first is the calculation of the gross direct and indirect expenses incidental to the operation of the school of nursing. The second consideration is the determination of the value of the service a student nurse renders in relation to a graduate nurse, and the expression of this in financial terms.

In studying the first of these, direct and indirect expenses, we are immediately confronted with the problem of whether to use the average cost or avoidable cost.

The average cost has been defined as the total expense of a particular activity, divided by the service units of the activity. The avoidable cost in this instance is the additional expense involved because we have a school of nursing.

There are certain direct expenses in the operation of the school of nursing which may be easily isolated in our accounting system. These would include such things as salaries of faculty and registrar, nurses' home matrons, housekeeping personnel assigned to the homes, and so forth. In addition, the budget expense codes could reveal expenses relative to classroom, office supplies, graduation, library, and subscription items, recruiting, repair of equipment, and telephone service in the nurses' home.

Mr. Lachner is assistant director, Ohio Tuberculosis Hospital, Ohio State University Campus, Columbus.

HARDER TO OBTAIN INDIRECT COSTS

Some of the indirect costs are not as easy to obtain, however. There are different methods of computation and the determination usually differs with the service and expense under consideration. Proper allocation is necessary of such expense items as housekeeping supplies, dietary (student nurse meals), laundry, heat, light and power, maintenance of buildings and grounds (lumber, paint, plumbing and electrical supplies), insurance on the nursing homes, and depreciation on the homes and equipment.

There are also other indirect expenses incidental to nursing education that may be considered, namely, a portion of the salaries and wages of employes engaged primarily for nursing service, but performing functions for the student nurse. These include the administrative staff of nursing service from the director of nurses through the assistant head nurse, and perhaps clerical workers. A questionnaire is commonly employed for this determination. Administrative expense also is included to pro rate the services of the administrator, purchasing and accounting office functions.

I believe that the basis for distribution should not be the extent to which nursing education uses a particular department or service of the hospital, but rather the extent to which nursing education adds to the cost of those services which are otherwise a necessary component of the hospital. This then would obviate the inclusion of a portion of salaries and wages for nursing service and the administrative pro rating of expense. Only to the extent that there were additional people added to the payroll because of the school of nursing would this additional expense be included.

On this avoidable cost premise, a cost study of the Iowa Methodist Hospital School of Nursing, Des Moines, Iowa, was undertaken in 1953; the results of this study will be referred to later. There was no attempt to make use of questionnaires seeking to determine time spent by various groups of hospital personnel on nursing education.

The other major consideration in a cost study on this subject has to do with the determination of the effectiveness of student nurse service hours. The value of, or effectiveness of, student nurse hours should be derived in such a way that findings in one hospital might be compared with others. The method recommended by Pfefferkorn and Rovetta[1] provides a valid comparison of the effectiveness of student service in the institution with the effectiveness in another. The basis of

[1]Pfefferkorn, Blanche and Rovetta, Charles: Administrative Cost Analysis for Nursing Service and Nursing Education. New York: National League of Nursing Education. Chicago: American Hospital Association, 1940.

hour for hour accomplishment is the assumption that in one hour a student nurse can accomplish the same amount of work as a graduate nurse accomplishes in that time. If graduate nurse and student nurse carry a like load, the service effectiveness to the hospital of one graduate is the same as that of one student nurse, or a one to one personnel as well as hour relationship.

In determining the effectiveness of student service in terms of graduate service, one should remember that the effectiveness percentage of student hours varies during different periods of the year, and that in making a cost analysis the effectiveness placed upon student hours should be derived not from one sampling period, but from a series of periods that are representative of changing nursing service and nursing education conditions during the fiscal term studied.

EFFECTIVENESS OF STUDENT HOURS

The findings at the Iowa Methodist Hospital, taken from six sampling periods during the year, show that the effectiveness of student hours was influenced by at least 15 different conditions. These conditions were:[2]

1. Period during the year. The effectiveness of the total student hours in the different class groups varies during different periods of the year. One condition which markedly influences the effectiveness is the proportion of the total student hours contributed by first-year students who are just beginning their regular full-time assignment on the wards.

2. Period during 24 hours. The effectiveness of all student hours varies during different periods of the day. From 7 a.m. to 7 p.m., it may vary from 0 to 100 per cent of that of a graduate.

3. Type of service. The effectiveness of student hours tends to be reduced on special services involving new learning processes and new types of skills, irrespective of the length of time students have been in school. Students, generally, have a lower effectiveness factor in the obstetric and operating room departments than in the medical and surgical units.

4. Diagnosis of patients. The diagnoses of patients may influence the effectiveness of students. Relief or temporary assistance cannot be sent to an acute communicable disease department from some other unit, nor can relief be sent from the communicable disease department to some other division.

5. Class of students. The effectiveness of students as a third-year class as a whole, second-year class as a whole, and first-year class as a whole is influenced by the number of students in each class on special services, particularly those services where the student hour has no service value, as in the diet kitchen and the formula room.

6. Efficiency of individual students. Students in the same class may have different effectiveness factors. This is a subjective factor and would be extremely difficult to justify accurately, but it is important and should be recognized.

7. Affiliating student. The effectiveness of an affiliating student is influenced by (a) the length of time she has been in the institution and (b) the experience of the student prior to affiliation.

8. Class hours. Class hours may or may not influence the effectiveness of students. In some instances, class schedules interfere with the most economical arrangement of hours for the nursing unit; in others, class schedules are arranged for the best economy of the nursing service.

9. Clinical teaching. The clinical teaching program, conducted on the nursing units by the head nurses, while it does lower the effectiveness of students to some extent, does not do so to any appreciable degree. The time spent by the students receiving instruction on the unit is minimal.

10. Construction and physical relationship of nursing units. The construction of a nursing unit or the physical relationship of one unit to another may require hour for hour substitution of graduates for students. Irrespective of the needs of the service or of the student's class year, such substitution represents "coverage" needs.

11. Size of visiting medical staff. A large visiting medical staff tends to raise the effectiveness factor of students by requiring hour for hour substitution of graduates for students. With a large open staff, the doctors have different needs, treat patients with the same disease differently, have various methods of doing things, and, in general, increase the amount of work to do on a nursing unit. When there are teaching rounds, a nurse must accompany the group, and this necessitates a nurse to satisfy the need.

12. Adequacy of staffing. The effectiveness of student hours varies with the adequacy of the nursing staff. The less adequate the bedside staffing, the higher the student's effectiveness, whether she is a third, second or first year student. In another staff situation, the student service is nearly or exactly as effective as a graduate service, depending upon the extent of other staffing.

13. Overstaffing because of student experience needs. The greater the overstaffing because of the student experience needs, the lower the effectiveness of student hours, whether hours are those of third, second or first year, or affiliating students.

14. Administrative policies of the nursing service. The administrative policies for particular departments may influence the effectiveness value of students. This is illustrated by difference in a substitution of graduate nurse hours for student nurse hours in the formula room in different hospitals.

15. Educational policies of the school. Educational policies of the school influence the effectiveness of the student body as a whole. An example of such policy is the exclusion of night duty from student experience.

DIRECTOR ASSIGNS STAFF

The director of nursing at Iowa Methodist Hospital, who has the responsibility for assignment of graduate and student personnel to services and who sees that each department is properly staffed, played an active part in the consideration of student effectiveness. She was thoroughly informed on the nursing service and nursing education policies of the hospital, and her decisions were properly guided by them.

The period of time considered was marked by an acute shortage of graduate nurses. It was in view of this serious staffing problem that the effectiveness percentage was assigned.

In considering the medical floors, surgical floors, obstetrical units, the nursery and delivery room, the pediatric units, isolation unit and outpatient clinic, the director of nursing believed that third and second year students carried a service load equal ro that of the graduates, and if the staff was made up entirely of graduate nurses, as it occasionally was, the same number of graduate hours would be necessary as third and second year student hours.

The first year students, who had entered school the preceding September, received their first assignment to med-

[2] Pfefferkorn and Rovetta: Op. Cit.

TABLE 1—Average Effectiveness Percentage of the Service Hours of All Students

Sampling Dates	Total Student Hours	Substituted Graduate Hours	% Effectiveness Student Hours
January 21	4034	3612	89%
April 30	3415	2984	87%
June 18	4853	3701	78%
August 20	4666	3966	85%
October 29	3947	3515	89%
December 17	3795	3427	90%
Totals	24,710	21,205	86%

TABLE 2—Summary of Nursing Education Income and Expense

Gross Expense Incurred for Nursing Education:		
Direct Expense	$ 70,163.07	
Indirect Expense	160,369.14	
Gross Expense		$230,532.21
Less:		
Income from Student Fees Retained by the Iowa Methodist Hospital	$ 10,915.00	
Value of Nursing Service Rendered by Student Nurses	217,949.80	
		$228,864.80
Net loss		$ 1,667.41

ical and surgical units the second week in June; hence overstaffing was necessary because of the sudden influx of the entire first-year class into the student nurse group and, because of the limited knowledge and capabilities of this group, members could be assigned only to medical and surgical floors, the operating room, and the diet kitchen. Thus it was thought that an effectiveness of 50 per cent should be given to this class for the remaining three months of its first year.

The sampling period taken two months later showed that the first-year students were then more flexible. They were assuming evening and night responsibilities and their usefulness to the nursing service in the hospital had improved to the extent that they were assigned an effectiveness of 75 per cent of that of a graduate nurse. However, if a student worked between 7 p.m. and 7 a.m., she was assigned an effectiveness of 100 per cent. Certainly if she were not there, and if she were the only nurse on the unit, she would have to be replaced by a graduate.

An analysis of daily time sheets showed that the assignment of second and third year students between the hours of 7 a.m. and 7 p.m. resulted in no overstaffing. In view of the floors being staffed with a minimum of second and third year students, we assigned an effectiveness of 100 per cent to these groups. The basic question was: If we abandon our school of nursing, how would we staff the floors? We could do this only by replacing with a graduate nurse each second and third year student, "man for man." During the 7 p.m. to 7 a.m. period, the second and third year students were assigned an effectiveness of 100 per cent, again assuming that if there were no school of nursing, they would have to be replaced by graduate nurses.

In the operating room, the student hour was rated as having one-half the effective value of the graduate hour. This deduction was made because of overstaffing owing to educational needs and because the operating room demands special skills and training that require time in which to become proficient.

Both first and second year students assigned to the operating room were assigned an effectiveness of 50 per cent. This was decided only after a thorough analysis was made of the educational needs in special skills required in the operating room.

In terms of graduate service, the students in the formula room and the special diet kitchen were given 0 per cent effectiveness. It was agreed that the students undoubtedly rendered service that would have to be supplied by some other type of worker were the student withdrawn. The substitution, it was thought, would in no case require a graduate nurse to fill the position.

Whatever test is made to determine the reliability of substitution, it must be practical in nature and applicable with reasonable ease. Daily time slips were set up to prove the validity of the substitution, the test being the proper distribution over a 24 hour period. If there were too many or too few graduates, the substitution procedure would be repeated until staffing satisfied the nursing education and nursing administration policies in the institution.

It was then on the avoidable cost premise, and in light of these considerations regarding the effectiveness of the student service hours, that the cost study was made of the Iowa Methodist Hospital School of Nursing.

It was found that the direct expenses amounted to $70,153.07 and the indirect expenses were shown to be $160,369.14, totaling $230,532.21. The income from student nurse fees retained by the hospital amounted to $10,915 for the year.

Table 1 shows that the total student hours available for service during the six sampling periods were 24,710 and the total substituted graduate hours amounted to 21,205. The effectiveness of the students, therefore, in terms of graduate hours, for the six sampling periods was 21,205 divided by 24,710, or 86 per cent. We now have a working basis for determining the financial value of student service in terms of graduate service. The hours of service rendered by the students during the year, taken from the daily time slips, totaled 202,744. This, multiplied by the effectiveness factor of 86 per cent, gives us the result: 174,359.84 effective hours of service rendered by the student nurse group.

The cost per hour of graduate nurse service was determined to be $1.25 per hour. The value of nursing service rendered by the student nurse is computed by multiplying the effective hours of service rendered by the students, 174,359, by the cost per hour of graduate service, $1.25. The result is $217,949.80, the value of nursing service rendered by student nurses for the year.

As shown in Table 2, the gross expense incurred for nursing education for the year was $230,532.21. This, minus $228,864.80, which includes income from student fees, and the financial value of the nursing service performed by the student nurses for the year, shows a net loss to the hospital of $1,667.41 for the year. Since there was an average of 147 student nurses available for nursing service, this shows a net loss of $11.34 per student for the year.

(*Continued on Page* 144)

Survey Offers Short Cuts to Savings

No hospital is too small to profit by a methods study and most communities can produce someone who is willing and able to do the job

OLIVE M. MURPHY and EMIL J. PANSKY

THERE is a solution to the problem of administrators who are frustrated by constantly increasing disbursements for both payroll and products. These disbursements may or may not be out of line with the volume of work done throughout the hospital. The administrator's frustration comes from lack of a measure. That measure can be supplied by an engineering study at a cost to the hospital that will more than likely be amply repaid by the return.

When we completed an extensive expansion program at Bartholomew County Hospital, Columbus, Ind., that permitted us almost to double our work in unhampered space, we were aware of the reluctance of department heads to "grow" into the expanded space. Rather, they felt the *immediate* need for a maximum staff and overlooked the possibilities of managing well with a staff proportional to the work load. Furthermore, the areas were much larger and so much more communication was needed that, at times, we were baffled by all the new relationships and their importance to efficient operation.

Some consideration by management had been given to the idea of an engineering study when we were fortunate enough to have a highly qualified production engineer volunteer to do our job on a part-time basis. Because of this limitation in time we decided to take only an over-all look at the operation. We held a conference with department heads to determine their ideas and feelings toward such a study. There was a general feeling that there was some duplication of effort within the departments and certainly among the various departments. However, it was admitted that no one in a supervisory capacity had the time, and most denied the ability, to stand back and take a systematic look at what was being done. So although the feeling existed, it was next to impossible to do much about it without outside help.

Miss Murphy is administrator, Bartholomew County Hospital, Columbus, Ind. Mr. Pansky is an engineer, Oakland, Calif.

GENERAL METHODS STUDY

As the engineer's study got under way and was gradually completed, department by department, it became clear that this was a procedural study and a study of paper work and forms as well as a conventional engineering survey in the general meaning of the term. The engineer decided at the start that at this stage there was no justification for attempting to employ any of the finer technics of time and motion study. Rather, he thought, a general methods study would suffice for the first review of the situation.

In retrospect, this proved to be a good decision for it has taken us a year to put into effect all of the recommendations that were generated, during his period with us, by the department heads as the various aspects of his suggestions were considered and reviewed. All departments excluding surgery were covered on a departmental basis. However, we made no attempt to touch upon the medical practice field. Ours was purely a hospital procedure and method study, not a medical staff study.

The actual method used varied from department to department but the general procedure was much the same throughout. Department heads and supervisors on all shifts were notified of the impending study by the administration. We attempted to impress them with the sincere desire of the administration to make these jobs easier, with more effective results. They were given full assurance that no full-time employe would lose his job. The administration stated that if it proved possible to cut back the labor force it would be done by using fewer temporary, part-time employes. (This is the group from which full-timers are selected in every department except professional and trained technical personnel.) This promise assured us of support of our employes.

In each case the administrator warned the department head when her department was coming up for consideration. Meantime the department head might have indicated and, in some instances, discussed possible trouble areas with the administrator. The engineer had been advised by the administrator of her general feelings on the quality and output of the par-

ticular department. Then the engineer-department head interview was held. Sometimes this was short but at times it took hours. After this interview a study was made of paper work and personnel flow throughout the department. At this time the usual forms and procedural diagrams were drawn. Often a great deal of time was spent with individuals in the department getting their reactions and listening to their thoughts on the subject and procedure in question. In some cases where the flow of paper work, or the actual procedure, was complex, minute and detailed diagrams were drawn to cover every eventuality and to trace all units of flow.

In some departments, such as housekeeping, maintenance and laundry, conventional engineering studies and layouts of location of the various units of equipment were made along with general motion and flow studies so the physical processes involved could be closely observed.

All the departments in the hospital were reviewed. These included dietary, housekeeping, laboratory, laundry, maintenance, nursing and business, which takes in admitting and PBX and x-ray. The procedures used in the outpatient department were also studied and the general administrative load was reviewed. This study included the work done by the administrator and had some organizational aspects. As we progressed we were involved in the personnel field, reviewing job analyses, comparative wages and evaluation procedure.

The study started in January 1954 and continued on a part-time basis for seven months, with the engineer on the job between eight and 12 hours per week. In July a full two-week period was taken to complete the review. In May 1955 the engineer spent a week on our job checking the changes we had made. During the original study it was found that for each department an average of between 10 and 20 suggestions was made by the engineer. Some were relatively insignificant but some were far-reaching.

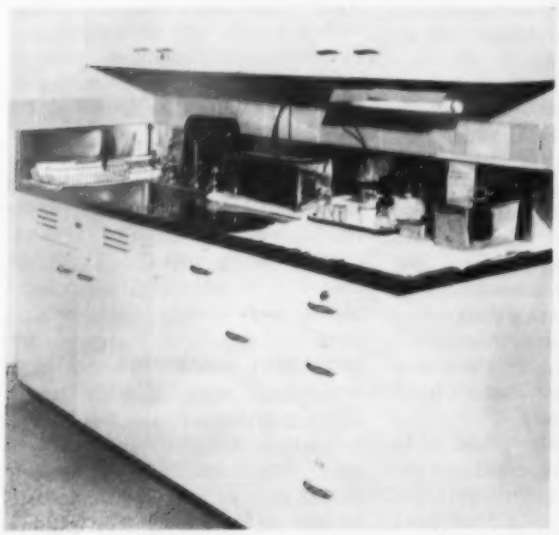
A written report for each department was submitted to the administrator by the engineer with not only the detailed deficiencies but also step-by-step recommendations as to the best way of bringing departmental performance up to maximum efficiency in method or in quality. As these suggestions came in, the administrator and the department head set to work to accomplish the desired end. This worked well, for many of the changes were made while the engineer was available for consultation.

Inasmuch as the procedure was approximately the same in each department, most of the technical details will be omitted in favor of reviewing the final results. In some cases the recommendations affected two or more departments. In these instances the conference system was used to ensure a good and informed working relationship between the departments involved. Some of the suggestions could only be instituted gradually but at the end of the year following the completion of our study we found most of the ideas had been carried out.

DIETARY

The dietary department was chosen to be first for several reasons, chiefly that it seemed to be well run; it was similar to commercial operations with which the engineer was familiar, and it had an enthusiastic, eager-to-learn dietitian in charge. He checked the physical layout of storage areas and kitchens, type of inventory control, and method of service to patients, personnel and guests, and determined the labor needs for the job by number and qualification. He was able to commend the dietitian on her on-the-job training program, job fitness, appearance and production.

Minor rearrangements of equipment in relation to the worker in diet stations were effected. Workers were taught to handle like things together as in shuffling of china, handling flatware and napkins. A double china standard was provided in one station that serves three units in relay fashion, allowing one maid to have a load in the dishroom while setup proceeded on the unit. The dietitian revised her schedules for special jobs and the weekly or monthly procedures. She posted in each station and work area



Cupboards in the utility area are numbered so that a nurse knows that behind a given number she will find a certain item and that this item can be located on any unit behind a door that is labeled with this number.

Laundry worker taking linen from the improvised "bin on wheels." Note that the height of the bin is such that the worker does not have to stoop. These bins can be moved to the mangle or the fluffing machine for easy loading.

the standard equipment for that area and received regular reports on it. Operation of the dishwashing room was studied and a more effective relay system was established. With these changes the time of one and one-half workers out of a staff of 15 was eliminated. The engineer discussed each recommendation with the dietitian first and then presented it to the administrator. This procedure was repeated in each department.

Our purchasing procedures were scrutinized and, here, the engineer gave the administrator and the dietitian a "rough" time. We followed every suggestion that was made to determine if other methods than the ones used were better. Finally, he bowed to purchasing with a flattering report on our methods. He seemed to be glad to commend us. We were happy to have had such a thorough check and not be found wanting. Furthermore, what held for purchasing in dietary held throughout the organization. He thoroughly approved our centralized method with special items in a few departments being requested on specification and purchasing being done by the purchasing department which, in our case, is the administrator's secretary and the administrator herself.

LAUNDRY

Many practical changes were made in this area. Because this department lends itself to detailed reporting, it will be used as an example to show the practical effectiveness of the study and implementation of ideas. Laundry service via requisition was abandoned throughout the hospital and established on a unit standard basis. Each unit of operation — nursing, x-ray, laboratory, physical therapy, and dietary—set up a maxium 24 hour standard and shelves were marked with that standard by item and number of shelf loads (stacks). If half a stack or two and one-half stacks were needed the standard was so indicated and the space was allocated on the shelf. These were determined by observation and count by ward personnel. Packages of linen per patient per day were discarded. An inexpensive cart loaded with a variety of items is now wheeled during bath time to the farthest locations in the two corridors that have only fair access to the linen room. Otherwise, the bedside worker takes the linen she needs each morning.

A big loose liner was devised for the canvas linen delivery carts to be inserted after each cart is emptied of soiled linen in the laundry. The cart is wheeled to the mangle or fluffing machines and the operators load it as they fold. Perhaps a couple of carts are loaded at one time, thus allowing some variety in each. As the laundryman goes to the hospital to pick up soiled linen from the chute, he takes a load of the clean product to the stations. Thus the stacks are continually being replenished and little is stacked in the laundry ironing room for rehandling. The liner is discarded with each load of soiled linen; that wash job constitutes the only procedure for which restitution has to be considered. The cost of the saved labor has paid for this many times over. A constant, abundant supply of linen is always available to nursing and other personnel and no time is wasted in making and handling a requisition. No counting is needed to make the requisition or to fill it.

Marking by department was eliminated as unnecessary under this system. A few items used irregularly were placed on a special request list and are ordered as needed by the ward clerk by telephone.

In the laundry the practice of dropping things into the canvas and metal carts, which are deep even in the smaller sizes, and removing them at the next machine was looked on by employes as a physically uncomfortable thing to do and a possible source of back strains. So we installed a spring-like gadget that raises the bottom layers to the top as articles are removed.

The whole operation in the laundry was considered in an effort to keep everything that was being handled on one level, *i.e.* slightly less than average waist height. We gathered up a half dozen old tables of various sizes from our "scrap attic," cut off the legs to the right height, inserted casters, and nailed 12 inch boards around the edge of the table top to form a shallow bin. These are wheeled between extractor, driers and mangle, making the flow easy and comfortable with little bending and lifting necessary.

All special items were placed in the big laundry operation: upholstery slip covers of all sorts, screen covers, and cubicle curtains. The general stock was increased by about one-eighth to take care of this.

The changes in the laundry really paid off in boosted morale and time saved. A study of the amount of work turned out during a four-month period prior to the changes and a comparable period afterward indicated a 13.5 per cent saving in man-hours. Conservatively estimated, the saving in labor for these four months was approximately $90 per month, whereas the cost of the minor conversions was very small.

MECHANICAL PLANT

The engineer drew upon his mechanical engineering background to analyze the operation of the mechanical plant. As a result we scheduled annual analyses of stack gases to determine efficiency of boiler operation. We made a study of the power factor of electricity coming into our hospital, checking incoming lines before it goes through the transformer, and it was found to be low. Small capacitors were added at a cost of $520. Within four months, with the power factor increased to 98.6, the saving in our electric bill was 13.4 per cent.

STORES

In stores, the introduction of requisition forms for all departments that carry the complete list of items used led to timesaving and fewer oversights in ordering. A few items were stored closer to the point of use, with labor saved in transportation.

MEDICAL RECORDS

A thorough look at medical records brought forth helpful ideas. All special medical record forms were eliminated. The nurses' daily summary sheet of patients' conditions was made to conform with information needed by the record librarian, thus saving the record room from having to hunt for the information each morning. Ward clerks were asked to bring medical records after dismissal at the end of each shift to the record room as they go off duty instead of a messenger from records picking them up once in 24 hours.

OUTPATIENT DEPARTMENT

Outpatient work in x-ray, laboratory and emergency room was critically analyzed from a traffic point of view. We finished by setting up a central registration point for all outpatients in these as well as physical therapy and pharmacy departments. No work was done in the department except as the registration slip, which

(*Continued on Page* 146)

He Teaches Nurses to Be Good Firemen

The fire safety training program instituted by Lt. Robert McGrath has overcome nurses' fear of fire and made hospitals safer for patients

DON WHARTON

ONE afternoon last April a dozen of us were standing in a large room on the seventh floor of Chicago's Presbyterian Hospital, watching a dramatic demonstration. Three nurses, stretched out on high hospital beds, were posing as helpless patients, and near each bed were metal buckets containing a half-inch of benzine. On one bed were cotton rags saturated with more benzine. Suddenly two firemen struck matches and tossed them into the buckets. Flames shot up two to three feet, burned hotly. A match was touched to the saturated rags; there was a startling puff, then a flaming fire only a few inches from the reclining nurse's back.

Now seven fires are raging in the room, and a signal is given to four nurses waiting outside the doorway. They walk in, calmly go to work carrying the patients out and fighting the fires. In 57 seconds of perfect teamwork, never running a step, they clear the room of "patients" and get five of the fires out. In four more seconds the nurses have all fires out.

Now the onlookers move to the hospital courtyard, stand there peering up at a fire escape which rises to the seventh floor. We see a white blur at the top—two nurses carrying a 175 pound man out on the fire escape, around a turn, down a flight of steps, around another turn, down another flight to the sixth floor. They are followed on the fire escape by another pair of nurses, carrying a man who weighs 220 pounds. The two pairs move at a steady speed, never pausing or faltering, as confident as West Pointers on dress parade.

Two years ago there wasn't a nurse at Presbyterian who knew how to carry a bedfast patient down a fire escape, or how to handle fire extinguishers and hose lines. But today this one hospital has 175 nurses trained and drilled in all emergency fire-fighting measures. Forty other hospitals in and around Chicago are giving such training to nurses and student nurses—and in some cases to orderlies, aides and other hospital employes in a program developed by a lone, resolute Chicago fireman named Robert McGrath.

Three years ago Bob McGrath was an inconspicuous member of the Chicago fire department. For 21 years he had battled fires of all kinds—in small hotels, apartments, shops, factories, slums. He knew how to handle a hose while standing on a 60 foot ladder, how to get helpless panic-stricken people down fire escapes and ladders. He had fought as many as 15 fires a day. Still, there was not much to set him apart from thousands of firemen who regularly did their dangerous duty. Then in late 1953 McGrath was made a lieutenant, put in the fire prevention bureau and assigned to hospitals.

Instead of merely looking for violations of fire codes, McGrath began pondering the problem of what hospitals could do in case of fire. Safety manuals said "move the patients," but the manuals didn't say how. There was a wide gap between fire protection theories and the practical ability of nurses and other hospital personnel to cope with an actual fire. Bed fires are not rare in hospitals, but the nurses knew little about getting a helpless patient out of a burning bed.

In 1953 our state fire marshals reported 1600 fires in hospitals and similar institutions, and the National Fire Prevention Association stated that loss of life in hospital fires was "often the result of failure or inability to remove helpless patients from the fire area."

One of the worst fires in American hospital history occurred in 1949 at St. Anthony Hospital in Effingham, Ill. In a hellish hour, amid crackling flames, the crash of breaking windows, the cries of newborn babies and screams of patients trapped in their beds, 74 out of 128 persons in the building were dead.

Automatic fire detection gear and fire doors could have confined the fatal flames. But in addition to structural faults in the building itself, investigation showed that the hospital personnel was not trained and drilled for such an emergency. Loss of life, both among heroic nurses and helpless patients, would have been less had hospital personnel been trained to act automatically.

McGrath knew there had been an estimated 1500 reported fires in hospitals and similar institutions in 1952, and that inability to move patients had resulted in loss of life. McGrath determined to find out what could be done.

First, he set down on paper various "carries" which might be employed by nurses to move bedfast patients out of

Nurses at Mount Sinai Hospital, Chicago, demonstrate their prowess in fire fighting. Above: Fred Levine, Mount Sinai's fire marshal, (in white shirt) supervises nurse using CO_2 extinguisher. Below: The author (l.) and Lt. Robert McGrath (r.) watch male nurse remove patient from a bed.

fire areas. Some were carries regularly used by husky firemen. Could women master them, and learn to handle heavy fire extinguishers and powerful hose lines? What *could* they do in an emergency?

To find out, McGrath turned to the head nurse of a Veterans Administration hospital in Chicago, who arranged for space and nurses for his experiments. Some 40 different carries were tested—and most of them quickly discarded.

Finally, McGrath had seven basic carries which women could use effectively. He found that with the right carry and a little practice a nurse could safely move a patient outweighing her by 50 or more pounds. He proved that in 39 seconds a well-drilled team of three nurses could turn in a fire alarm, move three patients out to a corridor, stretch a hose line and bring in a fire extinguisher.

But what if a fire struck at night, when a nurse was alone on her floor? McGrath, working with a stop watch, determined that one nurse could come from the floor below, another from the floor above, in seven seconds. He had an engine company, located half a mile away, make three practice runs to the hospital. He found that when an elevator was held for the firemen they could get a hose to the 13th floor in 2 minutes 40 seconds after the alarm went in. What happens during those 160 seconds obviously depends not on the firemen but on hospital employes, mainly nurses.

McGrath now moved operations to Provident Hospital, a 205-bed hospital on Chicago's south side. Here five nurses volunteered to learn the basic carries, then began working with fires set in the emergency driveway. They smothered fires with blankets, put them out with various kinds of extinguishers, tackled them with a standard fire hose. They were student nurses, 18 to 20 years old, 100 to 120 pounds; but McGrath found that with training a pair of them could successfully handle a powerful hose line.

Now he took them out on a fire escape and had them walk down in pairs, not carrying anyone but practicing the correct rhythm and footwork. In ten minutes a student nurse was being carried down the fire escape, first by one pair, then by another pair, then by four nurses using a blanket. Thus five courageous young women and an imaginative fireman disproved contentions of some hospital authorities that is was "hopeless" to consider nurses carrying patients down stairs and fire escapes.

Bob McGrath now had a definite program which the Fire Department offered to all Chicago hospitals. The first to respond was Presbyterian, where McGrath coached a dozen nurses. These then coached a nurse in each department, who began teaching others. The McGrath plan is now officially incorporated in Presbyterian's student nurse training. Teachers and students are now putting the whole course into a color movie, with parts in slow motion, which will be made available to other hospitals.

Back in the fall of 1954, of 101 hospitals offered the course, only five responded. But McGrath kept at it, visiting and telephoning hospitals, explaining, spending his own money, working nights and Sundays.

The nurses never let him down. When he gave the course at Loretto Hospital he had nurses carry a "patient" through fires set on each side of a doorway. Each day the fires were moved closer together, but the nurses would shoot right through, without flinching. In training nurses to handle a bed fire, McGrath played the rôle of the victim, lying on the bed next to a sheet of asbestos paper covered with benzine-soaked rags. A lighted match was thrown on the rags, the nurses practiced getting him out of bed first, and then smothered the fire with a blanket.

On high fire escapes McGrath always made the first carries with each nurse. He works like a good football coach, agile, coordinated, completely concentrated on the job at hand, never asking a nurse to do anything he doesn't do himself. I have seen him let two nurses carry him down a seven-floor fire escape. At Swedish Convenant Hospital one afternoon I watched him let four young student nurses, with only five minutes instruction, carry him down steep concrete steps.

Last summer McGrath began training teams from 16 Chicago hospitals

for a Fire Prevention Week demonstration. The climax was when these two-nurse teams suddenly appeared on the 11th to 18th floor landings of St. Luke's Hospital fire escape. Each team carried a "patient" down one floor, disappeared, formed a four-nurse team which, using the blanket carry, toted the patient down still another floor.

This ballet in white was a turning point for the McGrath program. In a week nine hospitals requested the course. Ravenswood Hospital has already trained over 150 nurses, orderlies, nurse's aides and maintenance men. Mount Sinai Hospital has trained 44, partially trained 136 more, and by the year's end plans to have 90 per cent of the nurses trained, ultimately every employe.

CITED FOR UNIQUE SERVICE

In January the Chicago Hospital Council gave Bob McGrath a citation for "outstanding and unique service." Later two Veterans Administration hospitals outside Chicago requested his course. In March he was called to South Bend, Ind., to start training nurses at St. Joseph's Hospital. Four South Bend firemen then took over and in a month had given the initial portions of the course to two-thirds of the hospital's 450 nurses and student nurses.

The National Safety Council and the American Hospital Association are now putting McGrath's technics into a 60-page manual, with step-by-step photos, for national distribution to hospitals, institutions and fire departments. They will initially print 15,000 copies, of which 7000 are planned for the member institutions of the American Hospital Association. Ray E. Brown, president of the AHA, says: "The fire emergency program which Lieutenant McGrath has developed has set a pattern for hospitals nationally. It is a real milestone in hospital safety. We hope each of our 5300 member institutions will adopt his program."

Every Hospital Should Have a Fire Truck

This one is neat, compact and inexpensive to make

EVERY hospital administrator is concerned with the terrible possibility of a fire in his hospital. Certainly there are many steps that he must take to prevent this possibility from becoming a reality. A complete fire plan, good fire drills at frequent intervals, constant reminders to the employes, and just good housekeeping, all play important parts in the over-all program.

At Somerset Hospital, Somerville, N.J., we felt that, in addition, our fire brigade should be furnished with an adequate supply of fire fighting equipment that would be readily accessible, portable, and sufficient for our purposes until the fire department arrived.

With the help of our chief engineer, a cart measuring 4 feet by 2 feet 6 inches and which stands 3 feet 6 inches high was designed and mounted on pneumatic wheels. The two center wheels are slightly larger than those on the front and back, for ease in turning. The truck, painted a fire engine red, has rubber bumpers on all corners and is enclosed so that no trash or dust can collect around the extinguishers themselves. Inside are placed two pails for sand, two large and two small carbon dioxide extinguishers, and two soda and acid extinguishers. The fire truck is located immediately beside our main elevator so that there will be no delay in delivering the truck to the scene of the fire.
—NELSON O. LINDLEY, *administrator, Somerset Hospital, Somerville, N. J.*

First aid for the fire brigade is contained in this truck which measures 4 feet by 2 feet 6 inches and stands 3 feet 6 inches high. It can be rolled easily on its pneumatic wheels and contains four carbon dioxide extinguishers and two soda and acid extinguishers plus two sand pails. The truck stands beside the main elevator all ready to go.

A Guide to Budget Management

Part 3—Preparing the Capital Expenditure Budget

H. W. MAYSENT

THE third major division of a "management budget" is the capital expenditure budget. While capital expenditures do not affect the net operation results, such expenditures do affect the hospital's cash position, unless the building fund cash is provided from other sources, such as building fund campaign and equipment donations. Therefore a special budget should be prepared for these items.

Exhibit 17—XYZ HOSPITAL
MEMORANDUM

Date:_____

To: All Department Heads
From: Accounting Department

As you know we are in the process of budgeting next year's expenses for the hospital. Will you please indicate below any anticipated repairs or new equipment requested for the coming fiscal year?

Will appreciate your returning this memorandum by _____.

Anticipated repairs:

List any large items of new equipment:

STEP 1

As is the case with the other areas of the management budget, department heads play an important rôle. They are asked to submit their requests for new equipment and major repair requests for the coming fiscal year. (See Exhibit 17.)

The budget committee approves these requests in conference with the department heads and other personnel as the case requires. Medical staff representation, either on the committee or as consultants, is of prime importance. In fact, those who are primarily concerned with major repairs should be consulted for their opinion. Budget development then becomes a part of the entire organization.

Some hospitals warn the department heads that if they do not include in their requests the needed equipment or major repairs these will not be forthcoming except in case of emergency. This procedure has considerable merit but its adoption must be left to the individual hospital.

In any event, the system for review and analyses of these requests from the department heads must be devised to ensure that careful consideration is given to each request.

Mr. Maysent is assistant director, Lankenau Hospital, Philadelphia. This is the third and concluding section of his article. The first and second sections appeared in the June and July issues of this magazine.

The author wishes to acknowledge the helpfulness of John Stagl, assistant director, Passavant Memorial Hospital, Chicago, in advising and guiding him in preparation of this material.

Exhibit 18—XYZ HOSPITAL—Capital Expenditures Budget

Item by Department	ADDITIONAL EQUIPMENT If Funds Available					REPLACEMENT EQUIPMENT If Funds Available				
	Estimated Cost	Necessary	Priority 1	Priority 2	Priority 3	Estimated Cost	Necessary	Priority 1	Priority 2	Priority 3
Administrative:										
Admitting electric typewriter	$387	$387								
One 8 by 11 drawer file	90			$90						
	$477	$387		$90						
Laboratory:										
Desk	$150		$150							
BMR machine						$550	$550			
Exhaust fans						50			$50	
Beckman model "6" Ph meter	300	300								
	$450	$300	$150			$600	$550		$50	
Etc.										
Total	$42,300	$6,400	$1,500	$5,000	$32,000	$45,000	$5,025	$1,580	$2,360	$18,250

STEP 2

Some hospitals classify these capital expenditure items as necessary, if funds are available: Priority 1, 2 and 3.

Using this method, the final capital expenditures budget would appear as shown in Exhibit 18.

Total Operating Budget

Exhibit 19 shows the form used for the preparation of the final operating budget. It should be noted that this form computes the total budget on a monthly as well as a total basis. The monthly basis method provides better inherent controls than does an annual budget.

Cash Position Forecast

The "cash position forecast" is based on experience coupled with the knowledge of fixed receipts of payments. This forecast is prepared subsequent to actual operation. The past experience factor is that experience under the present hospital collection procedures and methods of payment of invoices and payrolls.

This forecast based on the foregoing considerations will give the hospital administrator an insight into how much cash is available. See Exhibit 20 for cash position forecast form.

Final approval of the budget should represent the final phase of a management budget. There are necessarily two other considerations: (1) adjustments and (2) reporting budget results.

Adjustments

First, there must be inherent in the budget system a method of adjusting and of reporting this adjustment, if necessary, after the budget has been approved by the board of trustees. For example, unpredictable general salary increases or room rate increases may have to be made to meet some unexpected circumstances. The budget must be sufficiently flexible to reflect these adjustments.

Reporting Budget Results

STEP 1

When budget results are reported to the administration, a complete breakdown of the monthly budget should be given. This would include the following:

1. Monthly and cumulative summary of income and expenses. (See Exhibit 21.)
2. Total income for the month. (See Exhibit 22.)

(*Continued on Page* 152)

Exhibit 19—XYZ HOSPITAL
Budget for Year 19.... to 19....

	June	July
Income		
Gross earnings	$227,973.90	$230,045.42
Less free service and allowance	4,000.00	9,000.00
Net income	223,973.90	221,045.42
Nonoperating income	400.00	9,000.00
Total income	$224,373.90	$230,045.42
Expenses		
Operating expenses	$208,500.00	$218,000.00
Nonoperating expenses	3,000.00	3,500.00
Depreciation	9,000.00	9,000.00
Total expenses	$220,500.00	$230,500.00
Net income (or loss)	$ 3,873.90	$ (454.58)
Summary of Operating Expenses		
Salaries	$140,000.00	$146,000.00
Supplies	29,000.00	30,500.00
Food	18,000.00	18,300.00
Miscellaneous	15,000.00	17,200.00
Repairs and maintenance	2,500.00	1,800.00
Social security and annuity	4,000.00	4,200.00
Total	$208,500.00	$218,000.00
Statistics		
*Admissions		
Adults	677	681
Newborn	79	80
Patient Days		
Medical and surgical	6030	6058
OB	690	700
Total	6720	6758
Occupancy (per cent)		
Medical and surgical	85.2%	65.7%
OB	82.8%	64.5%
Total	82.6%	80.4%

*Estimated patient days ÷ average length of stay.

Exhibit 20—XYZ HOSPITAL
Cash Position Forecast

	Month			
	June Forecast	June Actual	July Forecast	July Actual
Cash balance beginning of month	$ 10,000.00			
*To be received from patients	227,974.00			
Add nonoperating income receipts	500.00			
Add income from investments	9,000.00			
Total Receipts	$247,474.00			
Disbursements				
Accounts payable supplies, etc.	$100,000.00			
Payroll (no. of pay periods)	100,000.00			
Interest	.....			
Amortization of mortgages	.....			
**Capital expenditures	6,000.00			
Total Disbursements	$206,000.00			
Cash balance end of month	$41,474.00			

*Collections assumed to be 30 days for patients' accounts—for this example only.
**Assumed to be nonreceivable from building funds.

ABOUT PEOPLE

Administrators


Horace Turner

Horace Turner, former administrator of Deaconess Hospital, Spokane, Wash., has been appointed administrator of Kadlec Hospital, Richland, Wash. The appointment will be effective when the hospital is transferred from the General Electric Company to the National Board of Methodist Hospitals and Homes about September 1. Mr. Turner has been doing hospital consulting work in Billings, Mont., since he retired from the Spokane position last year.

Dr. Gordon M. Meade, chief of clinical services at the Williamson Memorial Medical Center, Williamson, W.Va., has been named clinical director of the Miners Memorial Hospital Association, a chain of 10 hospitals serving beneficiaries of the United Mine Workers Welfare and Retirement Fund in West Virginia, eastern Kentucky and Virginia. He succeeds **Dr. Aims C. McGuinness,** who will return to private practice in Philadelphia.

Helen Shuford, R.N., has been named administrator of the Mission Municipal Hospital, Mission, Tex.

William A. Stoppani, whose resignation as administrative assistant of Danbury Hospital, Danbury, Conn., was reported in these columns in the May issue, has been named administrator of Horatio N. Woodward Memorial Hospital, Sandwich, Ill. Mr. Stoppani, a graduate of Columbia University's course in hospital administration, succeeds **Walter Schultz.**

Warren A. Oliver is the new administrator of Washington County Hospital, Plymouth, N.C., succeeding **R. M. Byrd.** Mr. Oliver, formerly a department head in the admissions office at the Medical College of Virginia, Richmond, Va., has recently completed the course in hospital administration at the college.

Victor V. Fisher, accountant at Memorial Hospital of Laramie County, Cheyenne, Wyo., has been named superintendent of the Monte Vista Lutheran Hospital, Monte Vista, Colo., replacing **Alvin Riffel,** who resigned to accept a hospital position with Hoisington Lutheran Hospital, Hoisington, Kan.

John Hurley, business manager of St. Francis Hospital, Grand Island, Neb., has been appointed assistant administrator of St. Catherine's Hospital, Omaha, Neb. Mr. Hurley is the current president of the Nebraska Hospital Association and a nominee in the American College of Hospital Administrators.


P. L. Scott

Peter Lindsay Scott has been named administrator of North Shore Babies' Hospital, Salem, Mass. Prior to his appointment, Mr. Scott was assistant administrator at Lawrence and Memorial Associated Hospitals, New London, Conn. He has also served as assistant administrator of the Fitkin Memorial Hospital, Neptune, N.J. Mr. Scott is a graduate of Columbia University's course in hospital administration, and served his residency at East Orange General Hospital, East Orange, N.J. **John L. Beckwith** succeeds Mr. Scott as assistant administrator at Lawrence and Memorial Associated Hospitals. Mr. Beckwith was formerly assistant administrator at Highland Hospital, Rochester, N.Y. He is a graduate of the University of Minnesota's course in hospital administration and served his residency at Memorial Hospital, Syracuse, N.Y. He is a member of the American College of Hospital Administrators.

Murray J. Rubin, controller of Hunterdon Medical Center, Flemington, N.J., has accepted the position of assistant administrator there. Mr. Rubin was formerly associated with MacNicol, Roswell and Co., New York accountants.

Carden M. Astin has been appointed administrator of Chilton County Hospital, Clanton, Ala., succeeding **David W. Morgan.**

Bert Davidson, administrator of Barbour County Hospital, Eufaula, Ala., has been named administrator of South Florida Baptist Hospital, Plant City, Fla., succeeding **Dean H. Byrd.**


Frank Muddle

Frank Muddle has been appointed assistant to the administrator at Cleveland Clinic Hospital, Cleveland, following the completion of his administrative residency at University Hospitals, Columbus, Ohio. He is a graduate of the hospital administration course given by Washington University, St. Louis. Prior to serving his Columbus residency, Mr. Muddle was in Germany with the Medical Service Corps of the U.S. Army.

R. H. Ward is the new administrator of Martin Memorial Hospital, Pell City, Ala.

Dr. Harry D. Propst, resident surgeon of the Wayne County Memorial Hospital, Honesdale, Pa., has been appointed temporary acting administrator there, replacing **William D. Pethick,** who died June 18.

Elmo H. Lund, administrator of Latter Day Saints Hospital, Logan, Utah, has assumed the duties of assistant to the administrator of the Dr. W. H. Groves Latter-Day Saints Hospital, Salt Lake City, Utah. **Sidney G. Garrett,** business manager at the Logan hospital, will succeed Mr. Lund.

Thomas A. Harrington, who recently completed his administrative residency at New England Center Hospital, Boston, has accepted the position of assistant administrator of Pittsfield General Hospital, Pittsfield, Mass. Mr. Harrington completed the hospital administration program at Yale University.

John L. Towers Jr. has been named administrative assistant of Baylor University Hospital, Dallas, Tex., after completing his administrative residency at Peninsula Hospital, Burlingame, Calif. Mr. Towers served his administrative internship at San Antonio Community Hospital, Upland, Calif.

Dorothy Gilman, formerly assistant administrator of Doctors Hospital, Seattle, has been named assistant administrator of the Medical-Dental Hospital and the Cobb Hospital in Seattle.

(*Continued on Page* 180)

A Good Press Is a Good Thing

A newspaperman reviews areas of tension between hospitals and the press and suggests ways of establishing understanding and good relations

HARRY BOYD

IF THEY have college degrees in public relations — and I'll be surprised if they haven't—how to handle the joint undertakings of hospitals and newspapers would be the $64,000 question on the final examination.

These undertakings require the meshing of the two vital community institutions which are perhaps the most complex and highly organized and are, at the same time, the most negligent about promoting public understanding of their operating problems.

Both newspaper and hospital staffs are heavily loaded with routine chores that are geared to rigid time schedules. Both are faced with many emergencies when everybody must pitch in and work twice as hard and twice as fast under twice the normal difficulties. And neither knows ahead of time when these peak-pressure periods will come.

NEWSPAPER'S MISTAKES SHOW

Most of a newspaper staff's mistakes show up in the paper every day for everybody to see and criticize. A good many of a hospital staff's mistakes show up in the paper, too, although they aren't always recognized as such.

So we newspaper and hospital people have a good deal in common. The similarity of our miseries should support a friendly bond of sympathy and understanding between us. The first principle of good hospital-press relations, it seems to me, should be to cultivate that natural bond.

Mr. Boyd is editor of the Cedar Rapids Gazette, Cedar Rapids, Iowa.

Newspapermen ought to make more of an effort than they do to know the operating problems of hospitals and to understand the reasons for hospital policies.

By the same token, hospital people ought to make more of an effort than they do to know the operating problems of newspapers and to understand the reasons for newspaper policies. This should happen not only at the top administrative levels but throughout both organizations.

MUST UNDERSTAND EACH OTHER

Certainly if news from hospital sources is to be handled satisfactorily, the newspaper and hospital people who are in direct daily contact must know and understand each other's problems.

They are most likely to have this understanding if their contacts are on a face-to-face basis. The reporter and the person who gives out news from the hospital should know each other well and see each other frequently, preferably every day. And both of them should be highly responsible, dependable persons.

Hospital news is too important for makeshift handling. It nearly always involves names—the names of people who are undergoing experiences which they and their relatives and friends will remember for a long time.

Hospital news often involves information of a distinctly personal nature and skirts closely the delicate relationship between doctor and patient. The line is not always easy to define between what the public is entitled to know and what is none of the public's business.

Wherever possible the hospital should be on the assigned daily run of a fully competent reporter and should be covered in person, not by telephone. Both the reporter and the hospital person charged with giving out information should have a good basic understanding of what is news and what isn't. And both should be deeply impressed with the importance of accuracy.

This basic understanding about news should extend also to desk editors at the newspaper office and to key personnel throughout the hospital. Sometimes in an emergency the regular information contact can't be reached and the substitute or the floor supervisor isn't sure what information is normally given out. So she refuses to give out any. This often leads to heated words or rash actions or both.

There is no good excuse for that and adequate staff instruction, both in the hospital and on the newspaper, would prevent it.

IOWA'S PRESS CODE

As to what is legitimate news from hospitals, that was set forth in general terms several years ago in the Code of Cooperation worked out by the Iowa press, radio, medical, hospital and nurses associations. Most Iowa institutions have subscribed to that code. But if they are like me, most of them haven't read it over for a long time. It may be in order to refresh our memories on certain points.

The code is based on two fundamental considerations:

1. That the primary obligation and responsibility of all doctors and all hospital personnel is the welfare of the patient.

2. That newspapers and radio news broadcasts exist for the common good, to bring matters of general interest and importance to the public quickly and correctly.

SHOULD DESIGNATE SPOKESMAN

Among the guiding rules the code suggests are:

1. That the hospital shall designate a spokesman who is competent to give authentic information to newsmen at any time of the day or night, as rapidly as possible, without interfering with the health of the patient.

2. That the newsmen shall be given the following information in emergency or accident cases: name, age, address, occupation and sex of the injured; nature of the accident; extent and seriousness of the injuries, and deaths.

3. That newsmen, in cases of illness of a personality in whom the public is rightfully interested, shall be given the nature of the illness, its gravity and the current condition, with the consent of the patient or next of kin.

On the other side the newsmen are expected to cooperate by:

1. Refraining from any action or demand that might jeopardize the patient's life, health or legal rights.

2. Reporting authorized direct quotations from doctors or hospital authorities accurately, both in content and in context.

3. Not publishing material designed solely to exploit the patient, doctor or hospital.

4. Making all reasonable effort to obtain authentic information from qualified sources before publishing or broadcasting news on matters of general health.

That seems a fairly reasonable set of ground rules. It enables the press to do its job without any undue imposition on the doctors or hospitals. It is substantially the understanding on which we cover hospital news in Cedar Rapids and we have found that it works well, for the most part. I think our relations with the hospitals are better now than they ever have been. At least they are from our point of view.

Most doctors seem to realize that the reporter has a legitimate job to do and are willing to cooperate along the lines laid down in the code. Hospital people are quite cooperative.

There is still room for improvement, of course. A few doctors still seem to think of newspaper reporters in terms of the sensation-seeking smart-alecks they used to see in the movies, when they went to movies. They need to get themselves up to date and realize that the newspapers have done as much to rid their ranks of charlatans as the doctors have done to rid their ranks of quacks.

There are also a few doctors who stretch their professional code of ethics to justify a public-be-damned attitude on all matters involving news of their patients.

But these are problems of education and enlightenment. They will take time and our feeling is that the burden of initiative lies with the reporter.

There are a few doctors who justify a "public-be-damned" attitude on all matters involving news of patients.

Given a chance, he must make an extra effort to prove to the doctor that he can handle a story with restraint and accuracy and can be trusted not to use off-the-cuff material.

DON'T BOTHER DOCTORS

The reporter also must use a little common sense consideration in covering hospital stories. If an accident happens well ahead of his deadline, he should get all the facts he can from the police and other sources first. He knows the doctors and nurses are busy with their emergency work and should avoid bothering them until the pressure is off. He shouldn't expect an accident victim to tell him his middle initial while the surgeon is patching up his skull. For the time when the reporter is up against a deadline, it usually is possible to persuade some other hospital administrative official to get the vital information that he needs.

Another arrangement that works well, if you can get it done, is asking the hospital to provide the newspaper with a copy of the daily list of admissions. This lets the paper know when anyone with special news value is hospitalized early enough in the day so the news can be handled carefully and with a minimum of inconvenience to all concerned.

Some hospital administrators may balk at this but I see no good reason they should if the proper understanding is reached on how the list may be used. A proper understanding might well be that, unless the sick person is a public official, the information will not be used without consulting the attending physician and getting permission from the next of kin.

Most of these arrangements for the handling of spot news are primarily for the benefit of the news media rather than the hospital. However, the news media are in a position to do some things in return which benefit the hospital and the doctors.

These things lie in the realm of news and feature stories which have incidental propaganda value for hospitals and the medical profession. And just in case there are any lingering doubts that the hospitals and doctors could use some propaganda to improve their public relations, I quote part of a letter I received recently from an irate subscriber.

HE DOESN'T LIKE HOSPITALS

A day or two before we had published a story about the death of an 84 year old man whose relatives said they had been unable to get a doctor to come and look after him.

"How long are the people going to submit to such inhumaneness?" this letter writer wanted to know. "There is much publicity of traffic tragedies in the papers, but no notice is taken of tragedies such as this which happen every day in Cedar Rapids—the refusal of doctors to make house calls and the turning down of the sick by hospitals because they have no insurance and no immediate means to pay.

"Most doctors refuse to make house calls even though they know the patient is able and willing to pay. Hospitals are cautious in admitting patients who have no insurance. A middle-aged woman was turned away from one of the hospitals. She had been stricken

with epilepsy while at work in a local restaurant. The ambulance attendants refused to touch her until the employer guaranteed payment. She walked home to die unattended in her room a few days later.

"Not long ago the same hospital refused to admit a sick little boy because the father was unemployed and had no insurance. Yet they call themselves a Christian institution!

"Something should also be done about the exorbitant fees the hospitals charge for their services. They pay shamefully low wages, yet they are always bemoaning a shortage of nurses. The average waitress or factory worker earns more than the most highly trained nurse, yet the nurse works harder than any of them. My hat is off to them. They are the true Christians in a cold-blooded organization."

"$3.50 FOR SURGICAL DRESSING"

"Insurance rates are constantly increasing, and it is no small wonder when we have to pay $3.50 for a surgical dressing which consists of the application of a band aid.

"Doctors, hospitals and some insurance companies raised quite an uproar when former President Truman proposed socialized medicine. It is a shame and a crime that his aims were not accomplished. It is not too late for the people to rectify this mistake."

The man went on to say there were other complaints he would like to make if he had the space, but that gives a rough idea of how hospitals stand with him.

We didn't print the letter. We did some checking and could find no foundation for several of his most positive statements. I wrote and told him that publication of the letter would be libelous unless we had reliable evidence to back it up. I asked him to submit such evidence if he had it, but never heard any more from him.

We don't hear from many readers who have as many gripes as that against the doctors and hospitals. But we get altogether too many letters and telephone calls indicating that the misunderstandings and antagonisms that man has are widely shared.

Many of those antagonistic impressions are not justified by the facts and the hospitals and doctors could correct them if they really worked at it. The newspapers could help them do it.

As a matter of fact, most of us want to help them do it and all of us should want to. Most hospitals depend heavily on more or less voluntary contributions from the public. When they go out after money, it is usually the newspaper that has to carry the bulk of the burden of putting the voluntary contributors in the frame of mind to volunteer. Anything that gives the public a more sympathetic understanding of the problems of hospital and medical care makes that job easier.

But we can't help much by just running editorials and puff stories praising the hospitals and doctors. Not enough people will read such stuff and those who do will discount it heavily as hot air.

What is needed are more genuine news and feature stories between fund campaigns—stories that will give the public more reliable information about the hard facts of medical and hospital service, stories that will let the public in on the unusual situations and dramatic achievements that highlight that service from time to time.

Considering that they are probably the most literally nonprofit enterprises I know of and have no dark trade secrets to hide, hospitals tend to be singularly mysterious about their operating policies and financial problems. And doctors are so afraid other doctors will accuse them of unethical advertising that some of them will buy only second-hand Cadillacs.

In my business I have to make more of an effort than most people to keep myself reasonably well informed. Yet I'll confess that, until about five years ago, I shared some of the same ideas of that letter writer about the rates hospitals charge and the hard-boiled attitude they take about getting paid. I also had some other equally firm convictions about the shortcomings of hospital service.

WHY HE CHANGED HIS VIEWS

Then I was invited to serve on the advisory council of a hospital. I began to read annual reports and examine the detailed monthly operating records. I heard more about troublesome heat losses, superannuated boilers, scarcity of interns, and such things. I learned more about the amount of service the Sisters provide without pay and the number of bills that are charged off to charity. I became familiar with the constant worry and struggle by administrators to make the operation come within shouting distance of breaking even. I got to know more of the warm human qualities of the people who make up the hospital staff. That information opened my eyes and gave me a markedly different attitude toward hospitals in general.

I think exposure to more information of that type would produce a similar constructive change in the public attitude toward hospitals.

I see no reason the highlights of annual, or even monthly, operating reports of hospitals shouldn't be published in the papers. Probably they'd have to be processed jointly by skilled newsmen and hospital administrators to make sure they gave a true picture that had meaning for the average reader. But certainly they'd make interesting newspaper copy, and certainly they'd create better public understanding of what hospitals are up against. If nothing else, they should throw a reasonable doubt on the assumption that hospitals charge $3.50 apiece for band aids.

It might even have a wholesome long-run effect to publish summaries of the monthly autopsy reports, although I won't hold my breath while we get that one arranged.

STUDIED VISITOR PROBLEM

We found considerable reader interest not long ago in some stories we published about the efforts of a joint committee from the two Cedar Rapids hospitals to find a solution to the hospital visitor problem.

Both hospitals were being overrun with visitors and it was felt that the congestion during visiting hours was interfering with the service to patients. No solution has been arrived at yet, but some interesting information was turned up.

One thing was that apparently there has been no thorough scientific study of the effects of visitors on hospital patients or any serious effort to determine an optimum visiting hours schedule.

People do have opinions on the subject, however. A poll of the doctors in Cedar Rapids showed that nearly all of them think restrictions on visitors should be tightened. Most of them felt that the number of visitors at one time and during each visiting period should be limited, that a shorter limit should be placed on the time they are permitted to stay, and that they shouldn't be allowed to smoke.

A poll of patients at one of the hospitals showed that they held substantially the same views, though not as strongly as the doctors.

(Continued on Next Page)

At that point we thought we had something. Then a later poll was taken of the patients in the other hospital. The results in several of the questions were almost exactly opposite to the results of the first patient poll.

So at the moment this particular research has disclosed only that questionnaires must be phrased very carefully and that there is a wide variety of opinion on the matter of hospital visiting hours. One interesting disclosure, for instance, is that a good many hospital patients would prefer that their friends send cards, flowers or gifts instead of visiting them. We have considered another poll to determine how many visitors visit only because they think the patients would be offended if they didn't and would really much prefer to send gifts or messages.

The point is that here is a hospital problem—and a fairly important one—on which nearly everybody has some opinions. It seems to me that is a challenge to devise some method of letting the public participate in reaching a satisfactory solution. You can't do much better in public relations than to put the would-be critic in the position of having helped make a decision he otherwise would feel free to condemn.

HOSPITALS ARE GOOD COPY

There is plenty of good feature copy in a hospital for reporters who can recognize it when they see it. Any organization that deals daily with hundreds of human beings in trouble is bound to run into frequent situations that are rich in human interest. As often as not the principals involved would have no objection to publication of the stories.

The catch is that the reporter, especially if he covers the hospital by telephone, seldom hears about them. They give the doctors and nurses something new to talk about, the patient discusses them excitedly with his visitors, but nobody thinks to tell them to the newsman.

Maybe nobody thinks they are any of the newsman's business, and maybe they aren't. But those human interest stories have great potential value for improving the public relations of both the hospitals and the medical profession. Nurses and doctors ought to be alerted to their possibilities.

Not long ago a doctor in a Cedar Rapids hospital opened the chest of a patient whose heart had stopped beating and massaged it back to action. That wasn't the first time that had happened but it was the first time it had happened in Cedar Rapids, and it made a whale of a good story—one we almost missed. We got fine cooperation from the doctor when we finally pulled it together and agreed not to use the names of the medical people, but we were about a week late on the story. We should have had it sooner.

There must be dozens of other good stories that slip by us every year—not crime and accident stuff but good solid medical stories that could dramatize for the public the fine behind-the-scenes service being given to the sick and injured.

THE "FIRSTS" ARE INTERESTING

There is a first time in every city for the use of every new wonder drug, every new medical and surgical technic. There is an interesting news story in nearly every one of those "firsts," and also in the final abandonment of long-used treatments and technics. Hospital staffs ought to be on the lookout for such stories and see that they are passed along to the reporters.

Material of this kind helps focus people's attention on their hospitals when they are not sick and irritable. It keeps them aware of the importance of the hospital as a health resource in the community. It helps them realize that they are getting something for their money in a hospital that tries to keep abreast of progress in medical care and advances in hospital technology. It gives them something to think about besides the daily room rate and those cryptic laboratory charges.

Recently two public-spirited citizens, Mr. and Mrs. Howard Hall, donated to the people of Cedar Rapids a cobalt radiation center. It should be in operation this summer and will be the first of its kind in Iowa.

What moved them to make that generous gift was the story of the results one of Mr. Hall's employes got from cancer treatment at a similar center in Ontario—precisely the kind of human interest story I've been talking about.

The first story on that radiation center was a hard one to prepare. I never saw so many people so nervous about the possibility of stepping on somebody's toes or stirring up misunderstandings. But when the story was finally okayed for release, it got statewide circulation and good play.

The chances are that the cobalt radiation center will draw the attention of a host of people in this area to Cedar Rapids. It symbolizes the advent of the Atomic Age in Cedar Rapids medicine and our community is proud of it—and of the doctors and hospital authorities who had a part in planning it. My guess is that it will make more people more willing to give when the next hospital fund drive comes along.

At the moment in Iowa, we have a special reason for hospital people to give closer attention to the intelligent development of good press relations. The prolonged hospital-specialist controversy has put a strain on the friendly relations between hospitals and doctors. That situation may get worse before it gets better.

If the issue is tossed into the legislative hopper next year, as is not unlikely, the hospital people may have some difficulty holding up their end of the argument. Hospitals, in the eyes of many people, are impersonal institutions — "cold-blooded," as the man says.

"Old Doc," on the other hand, is a human being, familiar to hundreds in his home town and respected by most. And there are more doctors than there are hospitals.

I am not presuming to say what this combination of circumstances portends. But I know it doesn't hurt an advocate of legislation to stand well with the people back home.

THEY MUST GET ALONG

However, this specialist controversy may show that doctors and hospitals are going to have to find a satisfactory basis for getting along. It is important to the people of Iowa that the harmonious relationship that has existed for years between their doctors and hospitals shall not fall apart, and that it shall be strengthened as much as possible.

The newspapers of the state are in a position to contribute a good deal toward that end by thorough understanding of the problems involved and by careful handling of the news.

I daresay there are plenty of things wrong with all of our Iowa hospitals, but there are more things right about them. A sincere and sustained effort by hospital people to cooperate with their local newspapers and broadcasters will go a long way toward keeping the picture in true perspective.

A Middle Manager Must Look Both Ways

The job of middle manager, or supervisor, is primarily to act as interpreter between administration and employes, so if he is going to do a good job he must understand the points of view of both

WILLIAM A. TAYLOR

SUPERVISION is classically defined as "the direction, accompanied by authority, of the work of others." It is the top-to-bottom "chain of command" which gives coherence to an organized cooperative effort. Because many of the managerial functions of the hospital administrator must be delegated, however, supervision in hospitals may be given the name and the definition of "middle management." By the same token, the hospital's department heads and supervisors may be called "middle managers."

Three major phases of the job of the supervisors or middle managers may be identified:

1. The substantive or technical phase involves the work to be done by those supervised.

2. The organizational or adjective phase is concerned with the policies and procedures according to which the work directed must be done.

3. The personal phase calls for impelling leadership of subordinates and development of a capacity for working harmoniously with associates.

TOO ENGROSSED WITH WORK

It is with the first phase of his job—the work to be done—that the middle manager is all too often completely engrossed. The strength of the middle manager rests in the fact that he thoroughly knows his own "shop." The specialized knowledge of his department's work is the middle manager's stock-in-trade and his legitimate pride. Administrators or assistant administrators are likely to make themselves quite unpopular if they are tactless enough to suggest that they know as much about the technical points of a department's functions as the department head does.

This attitude is not without its justifications. Today, it is a rare administrator or assistant administrator who could enter the clinical laboratory and accurately run a complete blood morphology analysis or who could competently advise the therapeutic dietitian with respect to the food chemistry involved in a low sodium ash diet—or who could safely initiate a gavage feeding of a premature infant—or who could avoid calling the maintenance engineer for help if he undertook to repair the controls of an air conditioning unit.

Yes, it must be admitted that credit for technical "know-how," by and large, belongs to the middle manager. He is the technical authority for his area of endeavor. It is he who must use his technical knowledge to bring together the manpower and tools allowed him by his budget in such a way that the tangible values of patient service result. He is the one who "hears things tick" in his area of endeavor. He is the one who most closely sees the concrete results of his department's operation.

It is understandable then that the middle manager becomes engrossed in the technical work performed by those he directs.

Unfortunately, the virtue of the middle manager's intimate familiarity with, and interest in, his own particular technical aspect of the hospital's function frequently carries its corresponding vice. The vice of his virtue often rests in a dimmed perception of the hospital-wide objectives which the administrator is trying to achieve and in a lack of appreciation of the over-all problems which the hospital faces. This, in turn, adversely affects the rôle of middle management as an extension of the executive function.

CANNOT BE ISOLATIONIST

One of the outstanding characteristics of an administrator's top level direction is that it must encompass the organization as a whole and deal with each issue in terms of the whole. As the principal support of the administrator, middle management must inject the generality of organization-wide purposes into its own individual operations. Toward this end, middle management can succeed only to the degree that it identifies itself with the broad purposes and the general problems of the hospital. On the other hand, middle management is likely to fail in exact proportion to the isolationism of its outlook.

If the middle manager excludes the needs of top management from his attention and is mindful only of the problems of his own immediate sphere, he in effect defaults on his basic duty, becoming a counter-influence to higher administrative direction rather than an agent of its extension.

In a very real sense, therefore, the

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effective middle manager must be two-faced. His responsibility for the day-to-day technical operations in the area he supervises compels him to turn one face downward. He is responsible for "getting the work out" in his area. He must see that "the job is done" in his department, section or unit by those whose work he directs. At the same time, however, he must turn another face upward. No matter how urgent and continuous a need there may be for his attention to the routines of his own shop, the middle manager must find time to look upward to the administrator, to determine wherein he must act as the internal agent of top management.

GETS PRESSURE TWO WAYS

So it is that the supervisor, as a middle manager, is constantly subjected to persistent pressures from two opposite directions. From below there is a never-ending demand that he exercise his capacities for organization, leadership, teaching, coordination and application of technical knowledge in coping with the problems encountered by the working force under his direction. From above there is a simultaneous and equally insistent demand made upon the middle manager. This is a demand that the middle manager closely identify both himself and his area of responsibility with the broad policies and over-all problems of the hospital as they are defined by the administrator and by the governing board.

Particular attention should be paid to the second face of the supervisor—the one that he as a middle manager must turn upward.

There are four fundamental things which the supervisor must do if he is to become a true middle manager who fully discharges his obligations to management. He must:

1. Thoroughly learn the over-all administrative philosophy, the hospitalwide objectives and general problems of the hospital as they exist in the minds of his administrator and governing board.

2. Interpret conditions and problems of his department to management as they relate to the perspective of management.

3. Communicate — upward and downward.

4. Never cease to be a representative of management.

The wise administrator and the enlightened board of trustees will explain themselves as fully as possible to department heads and other representatives of middle management. If top management expects support from the middle manager, it will do well to extend its hand to him, and convey to him a sense of hospitalwide objectives. Good top management will make its administrative philosophy known to the middle manager. It will also outline to the middle manager the relation of its philosophy to the hospital's over-all problems, objectives and policies.

The middle manager, for his part, must listen and read carefully and thoughtfully as top management "explains itself." The administrator's communication of the broad policies, purposes, plans and problems of the hospital may take many forms. It may come to the middle manager directly or indirectly, through policy and procedure directives, through departmental staff meetings, through minutes of meetings of special committees, and even through press releases of talks before lay or professional groups. Many facets of these issues and objectives will concern the organization as a whole. Improving patient care, developing sound interdepartmental relationships, reducing the cost of hospital care, implementing a sound hospital safety program, improving physician-hospital relations, interpreting the cost of hospital care to the general public—these are but a few aspects of the plans, policies and problems with which good top management will concern itself and with which good middle management must identify itself.

Psychologists contend that many people frequently listen without hearing and that they generally hear only what they wish to hear. Supervisors and department heads are not exceptions to this psychological theory. The words of top management frequently impress themselves upon their conscious awareness only when they relate to the middle managers' own thinking and reflect their own ideas.

It is essential that the middle manager listen, hear and understand *all* that is communicated by the hospital's administrative leadership. Having listened, heard and understood, the supervisor must then incorporate the administrative philosophy of management in his own thinking, planning and acting. He must identify himself and his department's activities with that administrative philosophy. He must further make this philosophy known to his subordinates, must indoctrinate them with this philosophy to the end that it becomes the frame of reference in which they work.

Does this imply blind subservience on the part of the department head or supervisor? Does this mean that the middle manager should dispense with personal judgment and follow without question the "party line" voiced by top management? Does this mean that the supervisor should have no part in the policy making process? The answer to all of these questions is "No!" If a middle manager assumes an attitude of "orders are orders" or resigns himself to the philosophy of "ours not to reason why—ours to do or seek another position," that middle manager is headed for serious trouble.

By the very nature of his responsibility, the department head or supervisor must not fail to speak up and point out pitfalls for management policy that only he can spot from the perspective of his own grass roots position and evaluate on the broad base of his personal line experience. He is not doing the job for which he is employed if he dispenses with his personal judgment. And he is obviously failing both his own department and the entire hospital if he neglects to warn management that a given policy may run aground on the hidden reefs of operational reality.

SHOULD HELP MAKE POLICY

The middle manager must participate in the policy making process if middle management and top management are to live and work in harmony. Here it is essential that the supervisor observe the second "must" that is prerequisite to good middle management. He must interpret conditions and problems of his department to management.

This interpretation to management of the departmental status quo must be more than monthly statistical reports showing number of units of work processed or number of units of patient service rendered. By interpreting departmental conditions and problems to management, the supervisor reveals much that is vital in the interest of good management of the hospital.

The scope of his interpretation should cover a broad area. Employe morale, progress in orientation and training programs, qualitative standards of performance met and not met, observance of safety regulations, trends in use of the department's facilities by the medical staff, status of relationships with other departments of the hospital, the

standing of the department with respect to public relations and patient relations, budget performance, need for procedural improvement, equipment and staffing requirements—these are some, but by no means all, of the things that should be interpreted by middle management to the administrator and through him to the governing board.

In military terms the middle manager is concerned with the tactics of administration, that is, control of day-to-day operations "on the firing line" so that the objectives of his department are achieved. Top management, on the other hand, concerns itself with plans and decisions of a strategic nature that bear upon long-range missions of the hospital. By translating strategy into tactics and by converting management's decisions into line activity, the supervisor actually formulates policy as a by-product of his middle management functions.

OFFERS USEFUL IDEAS

An enlightened administrator will also welcome the participation of middle management in policy formulation in other ways. Extensive experience in his technical field makes it possible for the supervisor or department head to furnish intelligence data for evaluating the durability of policy in the revealing glare of operating realities. The middle manager is also able to predict and identify trends which bear upon top management's planning. Helpful suggestions and new ideas from the middle manager will fall upon eager ears if the administrator to whom they are directed is a thoughtful strategist.

This matter of keeping top management informed brings to attention another "must" for the middle manager. The middle manager must communicate—*upward* and *downward*. This "must" presupposes that the administrator has done an essential part of his job well. It assumes that he has built up a good organization so that responsibility can be delegated. It also assumes that he has educated middle management to use this organization as a vehicle for communication.

In this discussion both supervisors and department heads have been referred to as middle managers. At this point it should be said parenthetically that it is not recommended that the various levels and degrees of supervisory responsibility should be ignored. Nor is it recommended that a supervisor ignore established channels of communication and command in the hospital's supervisory hierarchy. Going over the head of an established superior in order to keep the administrator informed is recommended only as a means of shortening the middle manager's career.

As stated before, it is essential that the supervisor communicate upward so as to keep top management informed of conditions and problems in the area he supervises. This information is essentially needed by management to evaluate line operations and to provide a basis for long-range planning. It is equally important that the supervisor's ideas and suggestions be communicated upward, through channels, for management's benefit in the formulation of policy.

Whether the upward communication will take written or verbal form will depend upon the supervisor's position in the hospital's supervisory hierarchy and upon the channels of communication available to him. The mediums of communication are not important so long as the message gets through.

If middle management is to operate as the extension of top level direction, it, in turn, must be kept informed by higher echelons of management. As stated before, the over-all administrative philosophy, the hospitalwide objectives and the general problems of the hospital, as identified by management, must be learned by supervisors at all levels. This means that continuing, accurate *downward* communication throughout the chain of supervising command is necessary. Each supervisor must indoctrinate his subordinates with the philosophy of top management and make sure that this philosophy becomes a part of the institutional climate in which the employe works.

TALK TO SUPERVISORS

Here again, the means of communication is not so important as the fact of communication. A word of frank advice, however, to the middle manager who wishes to satisfy himself that downward communication is adequate: "Middle manager, get up off your chair. Get from behind your desk. Talk *personally* with subordinate supervisors and to those whom they in turn supervise. Make certain that these people understand what has been communicated from above as well as the motivations, intentions and reasons behind the communication."

And, the final "must" for the middle manager: The middle manager must never cease to be a representative of management. No matter what his obligations to those whom he supervises, a supervisor's first allegiance is to management. By virtue of the responsibility delegated to him, the supervisor is an extension of top executive direction and therefore a direct representative of management. He is truly a middle manager. He must think and act accordingly.

Hospitals Report on Policy and Methods for Collecting Bills From Inpatients

THIS study concerns itself only with regular inpatients charged for services. It excludes bills referred to charitable agencies, government or insurance groups for payment.

A deferred payment plan is offered by 91 per cent of the reporting hospitals. This is sometimes done through a local bank, sometimes through the Reserve Plan, Inc., or by the hospital itself. Only 17 per cent of these make a charge for the service.

An analysis of the six hospitals which report that they do not offer a deferred payment plan shows that three have from 5 to 10 per cent of their patients leaving the hospital without paying their bills or arranging for future payments, and three show 1 per cent or less of their patients in this category.

MOST PAY BILLS ON DISCHARGE

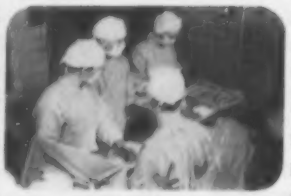
The average hospital shows the following: 65 per cent pay bills upon discharge; 30 per cent arrange for future payments; 5 per cent leave without arranging for payment.

Fifteen per cent of the hospitals reported *no* patients leaving unpaid bills; on the other hand, some hospitals

(*Continued on Page* 156)

Prepared by Dr. Louis Block from data and analysis supplied by Taylor, Harkins and Lea, Philadelphia, Research in Medical Marketing. This analysis is based on 81 hospital replies received in the third quarter of 1955.

Dr. Block is chief of the Research Grants Branch, Division of Hospital and Medical Facilities of the U.S. Public Health Service, Washington, D.C.



Film Tells Story of Service

Documentary color film is devoted to the history, background, philosophy and contribution of Catholic hospitals to the community's well-being

ST. LOUIS. — Latest addition to the growing library of motion picture films about hospitals is "The Dedicated," produced here recently by the Catholic Hospital Association of the United States and Canada.

A 28 minute, 16 mm. documentary in full color with sound narrative and musical score, "The Dedicated" may be rented for individual hospital use, and prints of the film may be purchased, the association reported.

The film has been shown to a total audience of 25,000, it was estimated, including a number of association conference and workshop groups, individual hospital audiences, and community meetings.

"The Dedicated" is devoted especially to the history, background, philosophy and work of Catholic hospitals. In addition to professional and administrative aspects of hospital operation, the picture features the rôle of religious orders and the hospital as a community institution. As indicated in the accompanying scenes from the film, and in the color picture on the cover of this issue, the picture shows actual hospital scenes, including operating and delivery rooms, nursing floors, patients' rooms, and various service departments. The picture shows doctors, nurses, administrators and other hospital personnel carrying out their regular duties.

"The film will familiarize the people of any area with the basic philosophy of the Catholic hospital, the scope of its services, as well as the integration of modern medical science into the age old concept of care for the ill and needy," the association said. "It also explains why costs that seem high to the average person are only just, in view of the variety and depth of the services available and rendered."

Response to the film on the part of Catholic hospital administrators and others has been enthusiastic, it was reported.

One nursing and teaching order has used the film especially as a recruitment tool for hospital personnel, nursing schools and religious orders, it is explained. This order has several prints of the film in constant use with high school and junior high school groups, mothers' clubs, auxiliaries, men's organizations and others, the association reported.

Another hospital presented the film at a community exhibition, showing it continuously in a hospital booth. "It has been a tremendous success—no one got up and walked out at any time," the Sister Superior reported. "High school youngsters who came in late stayed until they reached the exact spot where they came in; their expressions showed that they were really interested. We averaged 10 showings a day for 10 days."

Medical aspects of the film are realistic and accurate, Dr. James P. Murphy of St. Louis, one of the technical advisers to the association in preparation of the film, reported. "I was especially pleased with the technical aspects of the film in that it adhered to an accurate scientific portrayal of the subject matter," he said.

Scenes from "The Dedicated," documentary sound film. The scene showing delivery of infant is cover picture.

Does your staff have the right I.V. solution available for each patient's needs?

Specific fluid and electrolyte losses are now easily determined with modern tests like the flame photometer for potassium and sodium levels. As more is learned about fluid/electrolyte balance, a greater range of I.V. solutions is needed at the hospitals.

Cutter meets these needs with a complete line of special and standard electrolyte and nutrient solutions. Below are a few typical cases of how Cutter meets specific needs of each patient.†

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† The complete line of Cutter Special and Standard Electrolyte Solutions and Additives, arranged in a convenient mEq table, is available upon request.

Abstracted Case Histories

Case 1 – Male, 24 years. Condition: Herniotomy. Therapy: Prevent acidosis and restore electrolyte balance with postoperative use of Cutter Polysal®.

Case 2 – Female, 53 years. Condition: Resection of sigmoid carcinoma with ileostomy. Therapy: Correct acidosis, prevent hypopotassemia and maintain daily body requirements of electrolytes, carbohydrates and water with Cutter Polysal-M.

Case 3 – Male, 42 years. Condition: Alkalosis following pyloric gastric obstruction and gastric drainage. Therapy: Combat alkalosis with Cutter Invert Sugar 10% in Electrolyte Solution No. 3 (Cooke and Crowley's Gastric Solution).

Case 4 – Female, 27 years. Condition: Diabetic acidosis. Therapy: Alkalyze and stabilize with Cutter Polysal and then follow with Cutter Invert Sugar 10% in Electrolyte Solution No. 2 (Butler's Formula).

Case 5 – Male, 54 years. Diagnosis: Postoperative small bowel obstruction with drainage by Miller-Abbott tube. Therapy: Replacement of daily fluid and electrolyte losses with Cutter Invert Sugar 10% in Electrolyte Solution No. 1.

Case 6 – Female, 31 years. Condition: Severe diabetic coma. Therapy: Initial treatment with Cutter M/6 Sodium Lactate Solution.

Case 7 – Male, 42 years. Diagnosis: Gastric carcinoma. Therapy: Combat protein deficiency with Cutter C.P.H.* (5% Protein Hydrolysate in 5% Dextrose Solution).

Case 8 – Female, 1 year, 2 months. Diagnosis: Irritative diarrhea with hypopotassemia. Therapy: Restore fluid and electrolyte balance with Cutter KNL® (Darrow's Solution).

*TM

Make the Survey Before You Seek Funds

Any group that plans to build a hospital will profit by a conscientious survey of the number and kind of beds the community really needs

ALDEN B. MILLS

THERE are many types of surveys for hospitals. Surveys may be made to determine the fund raising potential of a community, to determine the site and soil conditions of a certain tract of land, or to consider the administrative efficiency of a particular hospital or the quality of professional practice (the medical audit that we hear so much about these days). However, I will deal with none of these but, rather, with community hospital surveys.

What is the purpose of a community hospital survey? In a small community it usually is undertaken to determine whether that community can and should have a hospital and, if so, its size and facilities. The surveyor may come to the conclusion that no hospital is needed or can be supported. Such a conclusion will almost surely be a sore disappointment to the people who sponsored the study, as they would be unlikely to have paid good money for it unless they had expected the answer would be favorable. Nevertheless, a conscientious consultant will be rendering the community a real service if, on the basis of his best judgment, he tells the community that a hospital is not justified. The community has a right to expect true objectivity from its consultant.

In a larger community, where one or more hospitals already exist, the purposes of a community hospital survey will probably be these:

1. To estimate for the entire community the total number of beds needed now (and possibly five, 10 or 15 years from now). To indicate how these beds should be allocated by services: medicine, surgery, obstetrics, pediatrics, psychiatry, communicable (including tuberculous), convalescent, long-term. Also to indicate the customary ancillary services needed, such as x-ray, clinical laboratory, emergency department, recovery rooms.

2. To indicate, on the basis of careful study of the community, the most efficient division of facilities into private rooms, two-bed rooms and multibed rooms. Many of us do wishful thinking about the percentage of private rooms needed. My partner, Otis Auer, recently made a study of 56 general hospitals (large, medium and small) in four adjacent Middle Atlantic states. Only four of the 56 hospitals in this study had an average annual occupancy in 1955 of 85 per cent or more in their private rooms. Nineteen of these hospitals had less than 60 per cent occupancy in such rooms. In nearly every instance the occupancy of so-called "semiprivate" rooms (what a specious term—how can privacy be "semi"?) was substantially higher than that of the private rooms. Yet (except in the maternity department) private rooms can be assigned without the limitations on sex and diagnosis which restrict the assignment of two or three bed rooms. In our desire to be ready at all times to serve our well-to-do patients, many of us apparently have been guilty of wasting the community's funds by building unnecessary private rooms. No other extravagance in all hospital activity equals the extravagance of the unnecessarily empty bed.

3. To determine the supplementary facilities that are needed. These include space for such important activities as rehabilitation (physical, occupational, speech and other therapies), outpatient department, home care, intern and residency training, and education of nurses (collegiate, professional, vocational).

4. To examine and recommend how the needed facilities can best be provided: through expansion and modernization of existing hospitals, through building of new hospitals, through mergers; under governmental, voluntary or proprietary auspices, or through nonhospital agencies. In explanation of the last category, I have in mind a splendid program for spastic children carried on by the public school system in Fresno, Calif., or more general rehabilitation programs carried out by societies for the crippled.

Frequently there will be a request for a survey of a single hospital and its prudent and desirable future course in a community where there are many hospitals. There is no pat answer. For the conscientious consultant to meet this request properly, it is necessary to conduct a full-scale community survey, even though only a single hospital is sponsoring and paying for it.

(*Continued on Page 92*)

Mr. Mills is a partner of Auer and Mills, hospital consultants, Santa Monica, Calif. This article was condensed from a paper presented at the Hospital Architects Conference of the Association of Western Hospitals, Seattle, April 1956.

Timing the community survey is important. Obviously it should not be undertaken until there is some show of public interest and concern with the problem. If nothing is going to come of it, the community might better save its money. Of course, the very fact that a survey has been authorized and conducted and a report presented will stir up some community interest. But that amount of interest is usually inadequate to obtain results. If all the desire for hospital facilities is concentrated in a small group, the chances for a successful fund raising campaign (or bond issue, if it is a governmental hospital) is slight.

Another point about timing is that the survey should be conducted *before* decisions have been made that may not agree with the conclusions of the survey. If the responsible group has already decided and announced publicly that it is going to build a 100 bed general acute hospital, it is embarrassing and impairs public confidence to have a survey say that a 50 bed hospital would be adequate.

Obviously if you are going to have a community hospital survey and an appeal for funds, the survey should precede the fund campaign. Furthermore, it should precede it by a sufficient margin so that there is opportunity to find out what questions people will raise and to give honest and satisfactory answers to those questions. In other words, there should be time to develop an informed public opinion.

A good survey can smooth the path in several ways for subsequent fund raising activity. Mr. Auer and I are not fund raisers. Professional fund raising counsels who have had experience in the East and in the Far West tell us that fund raising for hospitals in our western states differs from experience on the Atlantic seaboard or in the Middle West. In the Far West we do not yet have as deeply ingrained a tradition of public beneficence to hospitals as is true among our eastern confrères. Many large western corporations still have not established a policy of substantial giving to hospital capital campaigns. Few families in this area have made major contributions to hospital expansion generation after generation. Some campaigns even run into serious difficulties in obtaining the two or three key chairmen to head up fund raising efforts (the general chairman, special gifts chairman, industrial chairman and so forth). Yet in spite of these differences, well planned and well directed hospital capital programs are usually successful here.

Large donors, whether individuals or industries, want reassurance that a particular hospital project is sound from the operating point of view, that it meets a real community need, and that it is the best answer available to meet that need. Such donors are much more favorably impressed if the "case" for the hospital has been drawn from a careful, impartial and unbiased survey by an experienced consultant rather than prepared solely by the people connected with the hospital which is making the appeal. They may have confidence that the administrator of the local hospital is competent, able and fair. But by the nature of his employment, his statement of needs will not be considered to be entirely without bias.

SETTLE CONTROVERSIES FIRST

Fund raising succeeds best when controversies (if there are any) have been resolved ahead of time. In one southern California community, a fund raising campaign was stopped dead in its tracks for several months by a controversy over the location of the proposed hospital. Until this was settled, the campaign could not progress and there was a substantial loss of money and momentum.

Individual large donors themselves may not know enough about hospital service to be critical in their own right. But you can count on it that somebody in the community will ask the revealing questions. Potential donors of substantial amounts usually ask their friends and acquaintances about such contributions when they know they are on a prospect list.

There are a variety of questions that a good community hospital survey should answer:

1. Are the estimates of beds needed realistic in the light of present day conditions? On the West Coast particularly, we have seen a great development in the last 15 years of early ambulation. As the admissions to hospitals have gone up, the length of stay has gone down. This has a vital effect on our bed ratios and makes us rather shy of using ratios that have been worked out in other areas for other conditions.

2. Can the proposed number of beds be occupied to a satisfactory percentage? The studies of the Commission on Hospital Care have shown us that a satisfactory percentage of occupancy varies directly with the size of the hospital. But it also varies with the hospital's break-even point. With increasing costs, we have found ways of giving quite acceptable service and still maintaining higher occupancy than formerly.

3. Do the estimates take full account of local habits and customs? In a recent survey I thought that the obstetricians in a certain city were cutting the length of maternity stay so low (approximately 2.9 days) because of the crowded conditions in the hospitals. Before taking this for granted, however, I consulted all obstetricians in the area and found that they divided into three equal groups: those who would continue to discharge normal obstetric cases at the end of three days even if there were plenty of beds; those who would keep a patient four days, and those who would recommend that the patient stay five days. So our calculations were made on a four-day basis for this community instead of the five-day basis that I had first assumed. The result was a 20 per cent slice in the recommendation regarding the number of obstetric beds. (Account was taken, of course, of false labors, infections and the "feast or famine" nature of obstetrics so that there would be sufficient beds to meet the real needs.)

In still another California area, I found the average length of stay of normal maternity patients was only 1.9 days! Many of the Mexican mothers in this hospital stayed less than 24 hours.

Another local factor that may be of considerable importance is the relative division of hospital work between the general practitioners and the specialists. Such factors as wealth and customs of the people must be studied to assure sound planning.

4. Are the special health needs of the area given adequate consideration? Some areas have considerable migratory agricultural labor, or a great deal of substandard housing, or high infection rates from tuberculosis and syphilis. What is the general accident rate? What are the industrial accident hazards and what provisions are made for care of such cases? Age distribution has a double effect on hospitalization ratios since people over 65 have about twice as many illnesses, and stay in the hospital about twice as long per illness, as those in the 30 to 55 age group. But the effects of an

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older population on maternity and pediatric services are the reverse. Resort areas may have two or three times as many people in one season as in another.

5. Are the proposed plans flexible enough to adapt to rapidly changing medical technics? All of us are familiar with the declines in tuberculosis death and infection rates, the almost complete disappearance of the childhood communicable diseases, and the great changes in pneumonia. We may soon see the same thing in poliomyelitis. On the other hand, we are more and more conscious of the increase in cancer, heart disease, nephritis, the various degenerative diseases and other maladies that, up to now, seem to be an unavoidable concomitant of the aging of our population. To set up hospital plans that will not be sufficiently flexible to meet these changes that are already upon us and others which loom just over the horizon is shortsighted and wasteful.

We are probably on the verge of one of the greatest and most dramatic advances in the long history of medicine—one that in the future will be considered of equal significance with the discovery of the antibiotics. I refer to the great advances which I think are just around the corner in the field of mental diseases. This year marks the centennial of the birth of Sigmund Freud. One need not be a Freudian to acknowledge humbly and gratefully the tremendous impact which Freudian thought has had, and doubtless will continue to have, on our understanding of the mentally ill.

The use of analytical methods, electro-stimulative treatments, equanil, serpasil, miltown and many other new drugs has greatly strengthened the hand of the psychiatrist in his long and often seemingly hopeless efforts to restore patients to the point where they can again face their problems. There has been, within the past few years, a considerable transfer of psychiatric patients from hospital to office practice. Many patients who would have been hospitalized 20 years ago now maintain sufficient stability so that they can remain at home and see the doctor in his office.

The biggest change of all is the change that appears to be coming in public attitudes. Cancer and tuberculosis were once thought to be degrading and shameful diseases to be mentioned only in whispers. Public education has done much to dispel these unfortunate misconceptions. I believe in the future there will be as great a change in the attitude toward mental disease.

In view of these changes, I would enter a word of caution about the possibility of overdoing a good thing. I have preached for years and still preach the desirability of good psychiatric units in general hospitals. But today I am much more cautious in suggesting that they be of large size.

6. Does the survey give adequate and proper consideration to such services as home care and outpatient departments as partial alternates, under suitable circumstances, to hospital beds?

7. Will government agencies assume their proper share of the expense of the care for the indigent? What about the medically indigent? Can the indigent be brought under some form of prepayment plan? If so, what effect will this have on occupancy of the voluntary and government hospitals of the area?

8. Should the voluntary hospitals build endowment funds proportional to bed capacity? If so, in what ratio—$1000, $5000 or $15,000 per bed? Must this be a prerequisite to expansion, as some hospital trustees have occasionally maintained?

9. Are the existing or proposed educational programs sound and in line with current rapidly changing conditions in education? We all know what a hard time many well established hospitals have in filling their quotas for interns and residents, yet I see hospitals being started which include in their fund raising publicity a promise that they will have extensive facilities for intern and resident training. Do the recommendations of the survey make full and efficient use of existing public educational systems for nursing education and for inservice training programs?

10. Does the entire hospital program make a strong but entirely sound intellectual and emotional appeal to the interests of prospective donors and patrons? Are there good data for the fund raisers to use later when they are preparing their campaign?

Each hospital and community presents its own particular set of circumstances and deserves an individual tailor-made solution. Well considered answers to these and similar questions will provide a basic concept of the hospital's purposes and development which is even more vital than the essential soundness of its physical foundations.

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Plastic Dressings Meet Surgeons' Needs

Report on the handling, use, cost and advantages of liquid surgical dressing

FRANK C. SUTTON, M.D.

IN THE constant search for improvement of service and operating economy we are all concerned with the "benefit" of a new material or product. Often a genuine effort to exchange such ideas with supervisory personnel and others will develop significantly helpful new procedures. It is with a realization of the benefits available to general hospital procedures, as well as patient acceptance and comfort, that we have become interested in the use and handling of a comparatively new liquid surgical dressing.

The product, a transparent plastic spray-on dressing, appears in the "New and Nonofficial Remedies," 1955. A complete description of the product and its uses are published in detail. Its use in the hospital has substantiated its versatility, economy, ease of handling and many other features of value to the surgeon, the hospital, the patient, and the nursing care involved.

A paper from the University of Chicago,[1] in reporting the use of the product, states, "The objections to the classical methods of dressing wounds are well known, and need not be reiterated. Surgeons would welcome a dressing which is easily applied, subjects the patient to minimal discomfort in both its application and removal, permits observation of the wound from day to day without removing the dressing, and, at the same time, provides mechanical protection equal to that of the ordinary dressing. Our experience . . . indicates that this material is satisfactory in all these respects. . . . The matter of convenience and cost is of some importance. . . . Containers are easily stored, require less space than conventional dressing materials, and need not be sterilized. . . . The cost of the plastic dressing is somewhat less than that of the commonly used type."

Over a long period of continual improvement in operative facilities and technics and in postoperative management, virtually no change has been made in the type of surgical dressing used. Now a radical advance has been made with the introduction of a liquid surgical dressing which combines many qualities previously unrealized in the conventional type of surgical dressing.

EASE OF APPLICATION

The product simplifies dressing technic. It is easily applied in the following manner:

1. Spray a light coat (one sweeping stroke applied at a distance of about 10 inches) to the surgical wound and adjacent area of intact skin.
2. Allow film to dry for 30 seconds (sufficient time for the acetone solvent to evaporate).
3. Repeat "spray and let dry" procedure one or two more times.

The foregoing technic, indicated for dry, clean wounds, is modified[2] when application is made to wounds where hemostasis is not complete. In such wounds one applies a light coat, a layer of gauze for absorption, and an additional coat directly over the gauze and adjacent healthy skin area.

Application of the material is made directly over sutures and the wound area. To remove the sutures, one peels the film to suture line, cuts the sutures, then continues peeling (sutures will adhere to the film). One may also remove sutures without disturbing the entire dressing; simply rub lightly over the sutures with a cotton swab dipped in acetone. The film will dissolve and sutures may be removed as usual.

SUPERIOR WOUND PROTECTION

Studies,[3] confirmed by continued use of the plastic spray-on dressing, find advantages through protection that are not afforded by conventional dressings. Important wound protection features include the following: adapts to any body surface; provides mechanical protection; flexible; impermeable to bacteria and body fluids; nonadherent to raw wound surfaces; nonmacerating, allowing escape of perspiration; promotes healing.

A welcome addition to the surgeons' armamentarium is provided by this new form of liquid dressing which is easily applied from an aerosol container. Initial reluctance to accept a new technic is readily overcome as the surgeon appreciates the many ben-

Dr. Sutton is director of Miami Valley Hospital, Dayton, Ohio.


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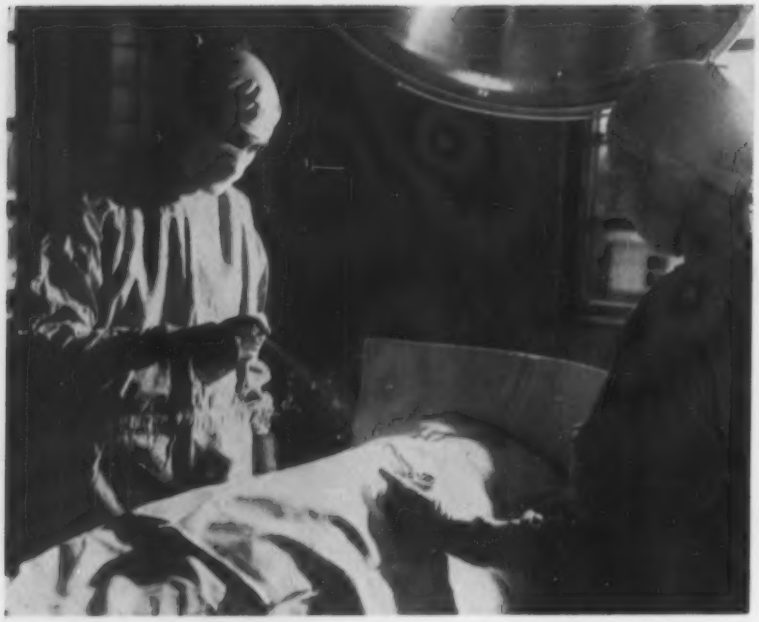
Bibliography of approximately 300 Xylocaine references upon request.

*Southworth, J. L., and Dabbs, C. H.: Xylocaine: a superior agent for conduction anesthesia, Anesth. & Analg. *32*:159 (May-June) 1953.

Astra Pharmaceutical Products, Inc., Worcester 6, Mass.



Surgeon applies liquid plastic dressing to an abdominal incision. First a light coat is applied to the wound and adjacent area; the film is allowed to dry for 30 seconds, and then the process is repeated once or twice.

efits, in addition to those already enumerated, which it offers:

1. Has extremely low sensitivity rate—about three-fourths of 1 per cent.
2. Simplifies dressing technic.
3. Affords examination of the wound without removal of the dressing.
4. Subjects the patient to minimal discomfort in both its application and removal.
5. Requires minimum redressing; dressing is removed with sutures, then reapplied.
6. Retards the escape of fluids and electrolytes from injured areas.
7. Permits ready examination of the entire chest or abdominal area.
8. Results in no limitation of motion of the chest or abdomen.
9. Allows for adequate ventilation postoperatively.

SOME OBJECTIONS EXPRESSED

Although the product does afford many advantages over conventional dressings, objections have also been expressed. Some of the objections appear to develop from improper application and handling of the material. Disadvantages which have been noted are as follows:

1. Drying time of film is too slow. This is usually caused by a heavy or "flooding" application of the material. In such cases the acetone is held within a mass of material and does not quickly evaporate. Proper application is important and the "spray and let dry" procedure explained in a previous paragraph should be followed.

2. The product "stings" upon application. In surgery, when the patient has been anesthetized this is not a problem. However, upon reapplication or when used in the emergency room, this can occur. Again, application is the corrective measure. Spraying two or three light coats to the wound area, with about 30 seconds between each application, minimizes this objection.

3. There is difficulty in controlling overspray. A masking technic should be used. When small wounds are dressed, a paper towel is often used. A hole is cut in the towel the approximate size of the area to be dressed, and the material sprayed to the wound through the opening.

4. Where infection with anaerobic organisms is suspected many physicians prefer not to use an occlusive dressing. In any event, tetanus antitoxin or toxoid should be administered.

5. There have been reports of difficulty in removing sutures and we find each surgeon employing his own technic. If the film is not of adequate thickness it is not easily peeled.

6. As with any new product possible allergenic factors must be considered. We have not encountered any such demonstrated case in our experience.

PATIENT COMFORT

Because the dressing is easily applied and redressing, except at suture removal, is practically eliminated, this procedure of protecting wounds has received immediate patient acceptance. We do find variations of use of the material among our staff—some surgeons prefer to place a single layer of gauze over the sutures before application of the liquid surgical dressing—but regardless of the technic used, we have not encountered patient objection. A number of technics may also be utilized for removing the dressings and sutures. Often the patient believes that the dressing alone has been removed when actually the dressing and sutures have been removed at the same time.

The lack of bulky dressings is a new and welcome experience to many people. Ordinary dressings, often abundant in gauze and adhesive tape, may prove a real obstacle not only to the surgeon and nurse but to the patient as well. The freedom of movement which the new plastic dressing makes possible encourages activity, and the lack of dressing pads and tape allows for adequate ventilation.

Tape sensitivity, a real problem with many patients—20 per cent tape sensitivity is reported—is entirely eliminated. In fact, it has become a general procedure with many physicians, where taping of a large area for supportive measures is necessary, to apply the liquid surgical dressing to the area, allow the film to dry, and then tape for support as needed. In eliminating tape, as well as gauze, maceration of wound areas is no longer a problem. The plastic film, in allowing the escape of moisture in the form of vapor, prevents macerated skin areas.

Wound protection is permanent when the plastic coating is used. The patient, fortunately, does not have to experience removal of the tape and gauze for examination—this, of course, is a real saving to the hospital, too. The new product is also effectively used in situations requiring skin protection from body fluids. This, as an

USES OF TRANSPARENT PLASTIC DRESSING

As a Surgical Dressing	As a Protective Coating
Major and minor surgery	To protect excoriated areas
Skin graft donor and recipient sites	To prevent excoriation in ileostomies, drainage of abscesses
Major and superficial burns	Under skintight casts
Decubitus ulcers	Covering skin erruptions
Vein ligations	To avoid urine burning in episiotomy
Mastectomy	To prevent irritation by tape

additional feature, has brought greater patient comfort. Ileostomies and colostomies, which always present a dressing and patient problem, are now much more satisfactorily handled by protecting the skin area around the surgical wound with this spray-on film.

ROUTINE USE

Material handling and personnel costs involved in hospital procedures cannot be overlooked in the consideration of old or new products. We have traced the benefits available at Miami Valley Hospital through the use of the new liquid surgical dressing and find that such material can offer many advantages. First, and certainly one of the most important, is that we are always working with a sterile material. The savings to the hospital mount when it is possible to dress all surgical wounds, except those wherein there is drainage, with a sterile film that is sprayed directly on the wound area.

Such procedure eliminates the handling, sterilization and rehandling of materials. In addition, adhesive tape is also eliminated. Not only are we eliminating the burdensome and costly job of sterilizing, but the many sizes of gauze and various mesh types are also held to a minimum in our inventory. These features cannot be too greatly emphasized. Where drainage is required, the spray-on material is used in conjunction with gauze for absorption. The gauze, however, will not adhere to the wound, and again, adhesive tape is eliminated.

In the pharmacy or central supply, where bulk storage facilities are always at a premium, the material again has a decided advantage. Packed in a carton of twelve 6 ounce containers, the material is easily stored and requires far less space than conventional dressing materials do.

Operating room procedures can also be hastened through the use of the spray-on dressing. The first application of the dressing is made in the operating room after which time the patient is taken to a recovery room where the second and/or final film is sprayed to the area. Even when two or three applications are made in the operating room, much time is saved when compared to the handling and application of gauze and tape to the wound area.

As the patient progresses to the surgical floor, there are further helpful aspects of this type of dressing. Here the supervising nurse, other nurses on duty, and the patient are to be considered. When they are bathing the patient the nurses are able to wash directly over the liquid surgical dressing without affecting it in any way. The dressing is waterproof and can be thoroughly washed with soap and water while the progress of the incision healing can be observed. At the time of removing sutures, all or part of the film may be removed. In either case, the plastic coating, obtained from the surgical cart or tray, can be resprayed to the area forming a continuous protective film dressing. The film is impermeable to bacteria, affords protection from irritation of bed clothes, and provides adequate mechanical support.

VERSATILITY

The new transparent plastic dressing provides new efficiency and versatility as a surgical dressing and protective coating. The terms "surgical dressing" and "protective coating" may at times seem difficult to differentiate. However, the ideal wound covering should offer the protection features shown under "Superior Wound Protection" and "Surgeons' Acceptance." These features, plus the modified technic of application with gauze for drainage absorption, affords an improvement in hospital surgical care that suggests a variety of possibilities. An attempt to classify a few of the many uses is outlined in the accompanying table. As experience is gained, new applications will suggest themselves.

In addition, our further experience is disclosing other helpful new applications. Its use in civil defense and disaster where large numbers of casualties may require first aid for burns also offers great promise.

ECONOMY

The economical use of dressings must necessarily include all factors relating to their costs from the time of purchase to the time of patient discharge. As previously mentioned, the product is sterile, which eliminates the time and personnel factor of material sterilizing; containers are easily stored, requiring less space than conventional dressing materials; dressings need not be disturbed for examination and patient care; the use of adhesive tape is eliminated.

Each 6 ounce container of the liquid surgical dressing provides sufficient material to cover 565 square inches at the suggested application of two or three coats (the completed dressing should be .002 to .003 inches in thickness—about that of tissue paper). The total cost of such a dressing is approximately ½ cent per square inch. For a 3 inch surgical wound the film covers an area of approximately 15 square inches (approximately 1 inch beyond each end of the surgical incision and 3 inches across the wound area). For a 10 inch surgical wound the plastic dressing should cover approximately 36 square inches. Cost per dressing, therefore, is based upon the size of the wound area to be covered. Savings of more than 35 per cent are realized. This saving is based upon comparative wound areas dressed with gauze and tape. It does not include the additional expense of sterilizing and handling gauze, and the frequent redressings required when conventional type dressings are used.

When the new liquid surgical dressing is considered in all its hospital phases of handling, use, cost and advantages to the patient, surgical, nursing and other personnel, it would appear to be a desirable adjunct to modern hospital practice.

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Current Status of Cancer Chemotherapy

THE three types of drugs currently useful in cancer chemotherapy are hormones, alkylating or cross-linking agents, and inhibitors of nucleic acid synthesis. Hormonal control of neoplasms began with the development of estrogen therapy for prostatic cancer by Huggins and co-workers. More recently, cortisone and ACTH have been used in the therapy of acute leukemia. After the discovery by Gilman and Philips of the suppressive effects of nitrogen mustard on lymphocyte formation, a variety of cross-linking or alkylating compounds were prepared. The clinically useful compounds of this type include HN_2 or mustargen, TEM or triethylene melamine and Myleran. Combined biochemical and synthetic approaches to inhibition of nucleic acid synthesis have made available aminopterin and 6-mercaptopurine.

Hormone Therapy

Estrogen Therapy of Prostatic Carcinoma. In the long and interesting history of cancer research a wide variety of substances isolated from natural sources have been tested for suppressive effects on tumors. Among the substances which have had a brief trial are bacterial toxins and extracts, such as Coley's toxins and the polysaccharides of Serratia marcescens. Other complex products of fungi, protozoa and viruses have received clinical trials. In more recent years, interest in antibiotics has again focused attention in the direction of natural products as potential sources of inhibitors of neoplastic growth. Thus far, the only natural products which have exhibited significant suppressive effects on the growth of human tumors are estrogens, cortisone and ACTH.

The earliest successes in cancer chemotherapy were obtained by administration of hormones.

In the course of studies on the effects of estrogens, androgens and orchiectomy on prostatic secretion of dogs, Huggins and co-workers found increased prostatic secretion following administration of androgens, and suppression of prostatic secretion following orchiectomy or administration of estrogens. In senile dogs, Huggins and Clark noted regression of prostatic tumors after orchiectomy or administration of estrogens.

Clinical testing of these findings was carried out on patients with prostatic carcinoma by Huggins, Stevens and Hodges in 1941. They reported that patients with prostatic cancer exhibited objective and subjective signs of improvement following estrogen therapy. The subjective findings, such as a decrease in pain, an increased feeling of well-being, and an increased appetite, are commonly noted by patients with cancer who are exposed to almost any experimental drug.

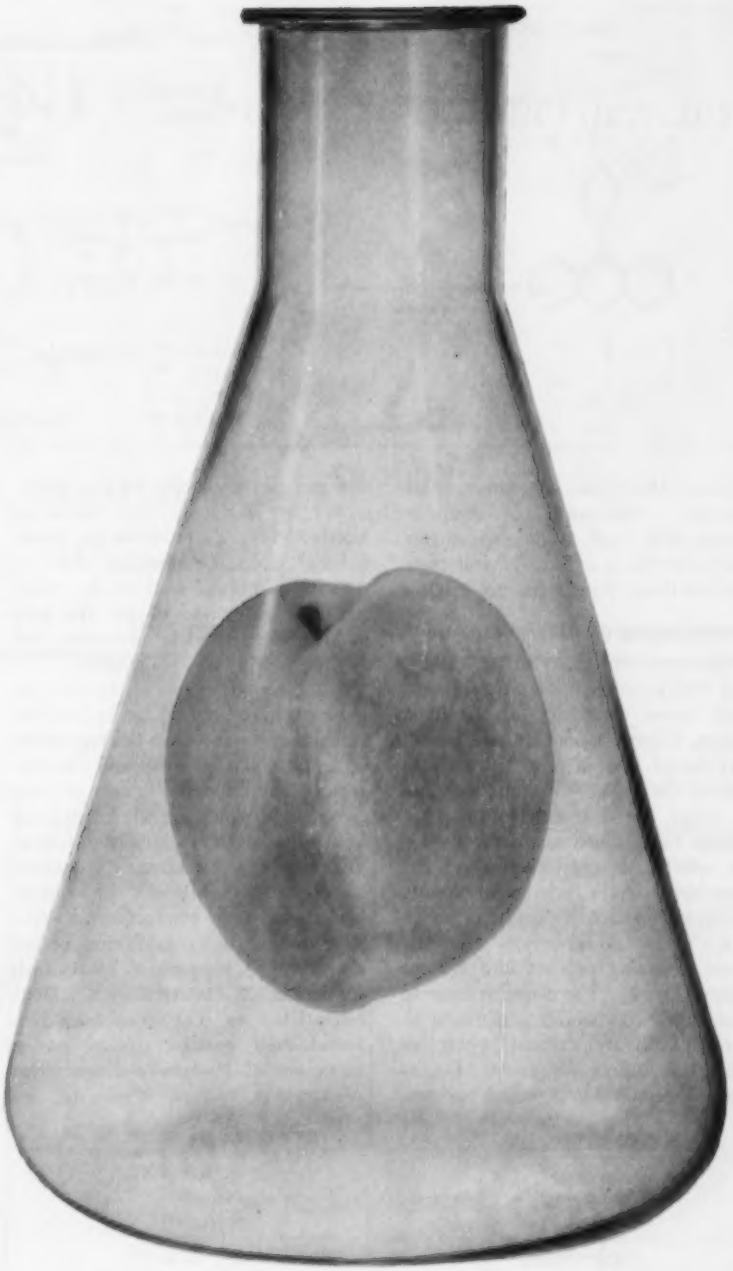
However, objective evidence, such as a decrease in the acid phosphatase level in the blood and roentgenographic evidence of improvement, was also noted in the treated patients. The tumors softened and decreased in size, the metastases in the bone shrunk, and osteoblastic activity was observed on x-ray examination. Weight gain and an increase in the hemoglobin concentration in the blood were noted in the treated patients. The plasma concentrations of alkaline phosphatase increased and the level of acid phosphatase decreased. Improvements were also noted in patients paralyzed by the pressure of metastic tumors on the spinal cord or nerve roots.

At present, stilbesterol, administered in doses of 5 mg. daily, is the drug of choice in therapy of prostatic carcinoma. In addition, the patient may be subjected to orchiectomy and occasionally, adrenalectomy, in order to remove another source of androgenic steroids. The side effects of these therapeutic measures include "hot flashes," mammary hypertrophy, and loss of penile erection. As is the case in most types of cancer chemotherapy, relapse occurs in a period ranging from four months to 3.5 years.

While the tumor is initially "dependent" for its growth on prostatic secretion, later (in its life history) it becomes "independent" of these hormones by some unknown adaptive process and, accordingly, becomes refractory to therapy. The "five-year cure" rate has not been remarkably different in the treated or untreated patients; however, the treated patients are frequently capable of normal activities, including work for a period of time.

Cortisone and ACTH. Cortisone and ACTH exert a suppressive effect on the progress of acute leukemias in children. Less significant effects have been reported in Hodgkin's disease, lymphosarcoma and multiple myeloma. The mechanism of suppression in lymphatic leukemia is not known, nor is the mechanism of production of lymphopenia in individuals treated with cortisone. Cortisone in doses of 25 to 50 mg. four times daily affords subjective improvement in 65 per cent of these patients. Objective hematological improvement is noted in from 30 to 50 per cent. In some instances, the rapid remission obtained with cortisone has been lifesaving.

The period of remission induced by these drugs is said to be shorter than that of the other chemotherapeutic agents used in acute leukemia and varies from 3 to 9 months. In adults with leukemia, little improvement follows the administration of ACTH or cortisone. Cortisone and ACTH have been reported to enhance the response to aminopterin by Wright and co-



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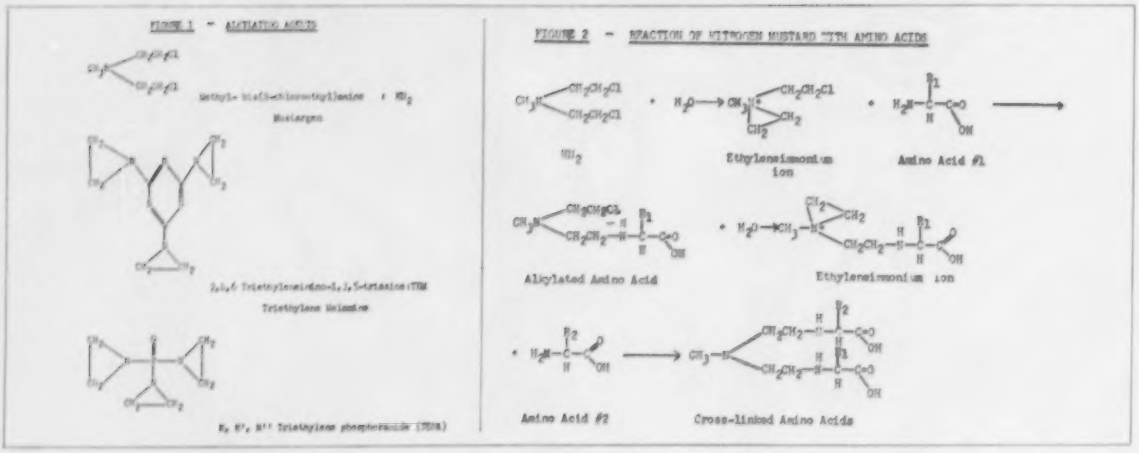


workers. Many clinicians routinely administer combinations of cortisone, aminopterin and 6-mercaptopurine. The side effects of ACTH and cortisone are those of hyperadrenocorticism.

Cross-Linking or Alkylating Agents

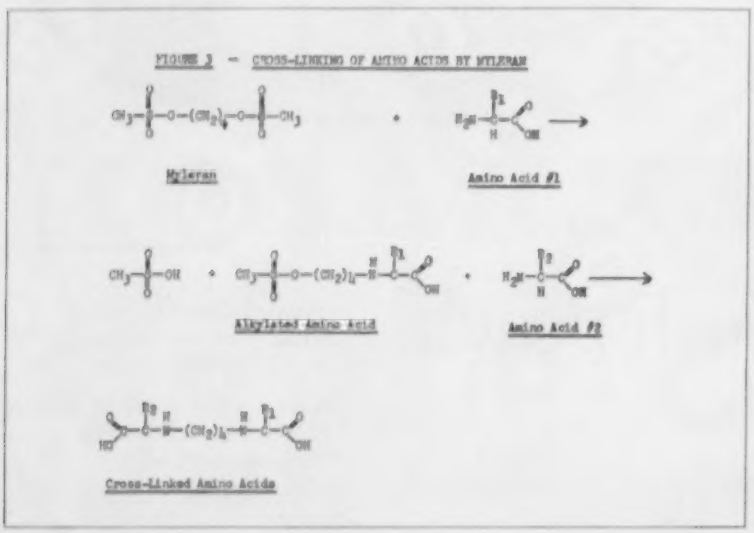
Nitrogen Mustards. After Gilman and Philips noted that nitrogen mustards were cytotoxic for lymphoid tissues, Gilman, Goodman and Dougherty found that these compounds inhibited the growth of lymphosarcomas in mice. The nitrogen mustards are omega halogenated alkylamines (Fig. 1), which are highly reactive in water, forming a cyclic ethyleneimmonium compound, which is capable of attacking a variety of substances at an H-R bond, releasing protons into the medium (Fig. 2). The nitrogen mustards can attack compounds containing hydroxyl, sulfhydryl, carboxyl, phosphate, imidazole and amino groups (Fig. 2). Since the molecule possesses two reactive groups, two molecules can be attacked or alkylated. This two-sided reactivity (Fig. 2) produces the "cross-linking" effects on proteins noted by Alexander and co-workers for these and other compounds of this type, such as Myleran, triethylene melamine, and the triethylene phosphoramides.

The cytotoxic effects of the nitrogen mustards have been related by Haddow and others to the cross-linking effects on intracellular proteins and chromosomes. The biological effects of these compounds, which are similar to those of X-irradiation, include the following: (1) selective effects on chromosomes, (2) inhibition of specific neoplasms, (3) production of fetal abnormalities, (4) inhibition of cell division, (5) suppression of antibody formation, (6) hematological and intestinal lesions. The compounds have found their greatest clinical use in treatment of Hodgkin's disease, lymphosarcoma, chronic myelocytic leukemia and bronochogenic carcinoma.

Nitrogen mustard, "Mustargen," is injected in doses of 0.4 mg. per kg. body weight in a course of therapy, usually in an intravenous infusion of an isotonic solution of sodium chloride. The courses are variable and generally consist of four equal doses given on consecutive days or two consecutive daily doses of 0.2 mgm. kg. These highly reactive compounds exert cytotoxic effects in a variety of tissues, such as the bone marrow, lymphoid tissues, intestinal mucosa and corneal epithelium. As might be expected, the nitrogen mustards, like their sulfur mustard analogues, are vesicant compounds for the skin and respiratory tract. Accordingly, they produce a number of unpleasant side effects, which include anorexia, nausea and vomiting within three hours after administration of the drug. Such effects can be decreased by barbiturates or antiemetic drugs.

In addition, severe depression of bone marrow may occur, limiting the frequency of the administration, so that therapy at intervals of less than six weeks is generally not recommended. Skin lesions such as herpes zoster or maculopapular eruption may occur, and in females menstrual irregularities frequently develop.

Triethylene Melamine (TEM). Since the cytotoxic action of the nitrogen mustards was attributed to the ethyleneimino groups which form in water, substances have been synthesized in which these groups were already present. Of these, TEM has proved to be a useful drug (Fig. 1). Although it exhibits cross-linking of protein molecules as well as other reactions of the nitrogen mustards, this compound is more stable in aqueous solutions and causes fewer acute toxic effects. Hence,



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hiccups
acute excitement
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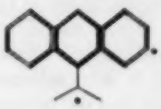

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Suppositories 100 mg.	Boxes of 6	1.53 box
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Tablets 10 mg.	Bottles of 50 Bottles of 500 **Bottles of 5000†**	2.13 each 20.24 each **170.00 each**
Tablets 25 mg.	Bottles of 50 Bottles of 500 **Bottles of 5000†**	3.03 each 28.79 each **243.00 each**
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triethylene melamine can be administered orally, in doses of 2.5 to 5.0 mg. daily, with little incidence of nausea and vomiting. Because it is more stable in alkaline solutions, it is administered with sodium bicarbonate. The weekly dosage varies up to 10 mg. and the monthly dosage ranges from 20 to 40 mg. The compound has found its greatest usefulness in Hodgkin's disease but is also useful in therapy of lymphosarcoma and chronic lymphatic leukemia. It is more conveniently administered than the nitrogen mustards, since it can be given to ambulatory patients. The toxicity of the compound is essentially that of the nitrogen mustards.

Myleran. Another in the series of cross-linking or alkylating agents is the compound "Myleran," a 1, 4-bismethylsulfonyloxybutane (Fig. 3). This compound was first synthesized by Timmis and studied by Haddow. It has been found to be capable of alkylating amino acids in much the same way as the nitrogen mustards (Fig. 3). As Haut and co-workers have pointed out, Myleran has found its principal therapeutic usefulness in the treatment of chronic myelocytic leukemia. The drug is administered in daily doses of 4 to 6 mg. to patients who are exhibiting an exacerbation of the hematological and clinical findings. The dose is continued at this level until a remission ensues at which time the drug is discontinued.

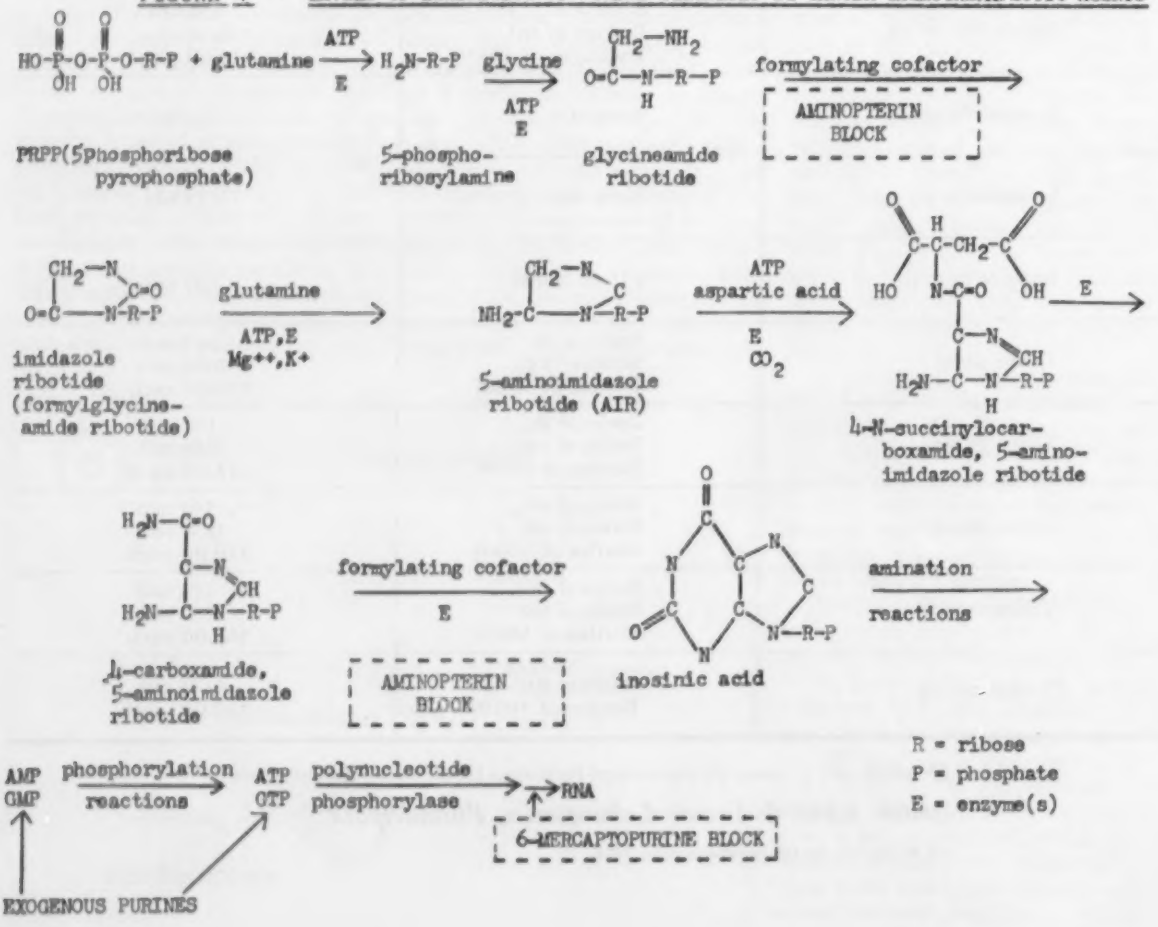
The drug may be continued for prolonged periods, *i.e.* from one to three months. As with most compounds of this type, toxicity to the bone marrow is an important side effect of the drug. Thrombocytopenia and hemorrhage occur occasionally and both cerebral hemorrhage and bleeding peptic ulcers have been reported. Leukopenia or pancytopenia has been observed, but these complications have been less frequent in individuals maintained at the moderate dosage levels noted here.

TEPA. For a time, the phosphoramides held promise as chemotherapeutic agents for cancer. Such compounds as N, N', N" triethylene phosphoramide (TEPA) have been reported to exert effects against neuroblastomas and malignant melanomas (Fig. 1). However, the results have not been as consistent or as long lasting as those obtained with other compounds of the ethyleneimino type. The compound N-(3-oxapentamethylene)-N', N"-diethylenethiophosphoramide is very effective against animal tumors and is being evaluated clinically at present.

Inhibitors of Nucleic Acid Synthesis

Biochemical Aspects. The most recent approach to the problem of chemotherapy of cancer has been the development of analogue inhibitors for intermediates involved in synthesis of nucleic acids. These inhibitors, aminopterin and 6-mercaptopurine, block important reactions in the sequence leading to nucleic acids. It has been known for many years that nucleic acids, of the type primarily in

FIGURE 4 — LEVELS OF INHIBITION OF PURINE SYNTHESIS BY CANCER CHEMOTHERAPEUTIC AGENTS



the nucleus of the cell, deoxyribose nucleic acid (DNA), and the type found primarily in the nucleolus and cytoplasm, ribose nucleic acid (RNA), are both high molecular weight polymers of the ribotides of purines and pyrimidines.

However, little information was available as to the mode of biosynthesis of these compounds until recently. At present, there is increasing understanding of the mechanism of synthesis of pyrimidines, and there is a great deal of information on the precursors, intermediates and enzymes involved in the biosynthesis of the purines (Fig. 4).

The studies of Buchanan, Greenberg and Kornberg and their colleagues have been integrated into a composite scheme (Fig. 4), which suggests that the ribose phosphate formed from the ribulose phosphate of the hexose monophosphate shunt is pyrophosphorylated to yield the compound 5-phosphoribosylpyrophosphate, the starting material for purine biosynthesis. This compound is aminated by glutamine in the presence of ATP and an appropriate enzyme to yield 5-phosphoribosylamine.

Glycine is added to the molecule by another enzyme system in the presence of ATP, and glycineamide ribotide is formed. This latter compound is formylated to yield an imidazole ring in formylglycineamide ribotide. This reaction requires the first participation of the "formylating cofactor" formed from formyl citrovorum factor. Glutamine again participates in the biosynthesis of the purine ring as an amino donor for the amination of formylglycineamide ribotide, and the product of this reaction is 5-aminoimidazole ribotide (AIR).

In the presence of aspartic acid, CO_2 and ATP, the appropriate enzyme system forms 4-N-succinylocarboxamide, 5-aminoimidazole ribotide. This large molecule loses the succinic acid residue to become 4-carboxamide, 5-aminoimidazole ribotide, which is formylated to yield the purine nucleotide, inosinic acid ribotide. This formylation reaction again requires the participation of the "formylating cofactor" formed from formyl citrovorum factor and the appropriate enzymes. Inosinic acid can be converted by amination and reduction reactions to adenine or guanine, the purines found in the nucleic acid. Some exogenous adenine can also be utilized.

Although the exact mechanisms by which these ribotides can be coupled to form the nucleic acids has not yet been elucidated for animal tissues, Ochoa and his co-workers have partially purified the enzyme "polynucleotide phosphorylase," which is capable of forming polymers of the nucleotides, whose x-ray diffraction patterns correspond closely to those of ribose nucleic acids.

Aminopterin. The continuing effort to produce inhibitors of this series of reactions is generally referred to as "rational empiricism." The initial attack on nucleic acid biosynthesis emerged from experiments of Farber and his co-workers who studied the effects of folic acid analogues on growth of transplantable mouse tumors. After initial observations that the di- and tri-glutamic acid derivatives of folic acid, diopterin and teropterin, respectively, enhanced the growth of the tumors, they shrewdly reasoned that analogues of folic acid might inhibit tumor growth.

Among the first analogues of folic acid synthesized by chemists at the Lederle Company was aminopterin, the 2,4-diamino derivative of folic acid, which was found to inhibit tumor growth. In clinical trials, remarkable, but temporary, remissions were obtained in children with acute leukemia. Although aminopterin is effective in therapy of lymphosarcoma, reticulum cell sarcoma, melanoma and sympathicoblastoma, it is still primarily used in acute leukemia. The N^{10}-methyl derivative, amethopterin, is therapeutically less active, but it is also much less toxic than aminopterin and, hence, is in greater use than aminopterin; the daily dose of aminopterin is 0.25 to 0.5 mg. daily, while that of amethopterin is 2.5 to 5.0 mg. daily. These compounds are thought to suppress formation of citrovorum factor from folic acid.

The reactions leading to the formation of the active cofactor for the "formylation reactions" associated with closure of the two rings of the purine molecule are not fully known, but it seems likely that the first reaction involves reduction of the pyrazine ring of the folic acid to yield tetrahydrofolic acid. The tetrahydrofolic acid is formylated to yield the citrovorum factor and this compound is believed by a number of workers to form anhydroleucovorin, a four-ringed structure, which may be the active cofactor. Inasmuch as the cofactor is essential for the synthesis of the purines for nucleic acid synthesis, compounds which inhibit the synthesis of the formylation cofactor also inhibit the synthesis of nucleic acids.

It is apparent that inhibition by aminopterin of so basic a process as nucleic acid synthesis will be reflected in toxic effects on tissues other than tumors. Among the side effects commonly encountered are ulcerations of the buccal mucosa, which may lead to gangrene in the cervical area, leukopenia and thrombocytopenia.

The incidence of remissions resulting from "antifolic" therapy range from 30 to 75 per cent of treated cases in various studies. In many instances, the child returns to virtually normal health and activity. The bone marrow content of "blast" cells may return to normal and in the peripheral blood, the white count may drop to as low as 3000 total WBC/μl. The therapy may be repeated as often as the marrow shows any signs of change toward the malignant state.

Unfortunately, the multiple pathways leading to synthesis of nucleic acids permit the tumor cells to escape ultimately from the controlling influence of the aminopterin so that in a variable period of time, ranging from six months to as long as five years, the drug-controlled remission ceases and the patient succumbs to the disease.

6-Mercaptopurine. A more recent addition to the armamentarium of the clinician treating leukemia is the drug "purinethol," 6-mercaptopurine. Following the discovery of Brown and coworkers that purines fed to rats could be incorporated into the nucleic acids of tissues, it became evident that exogenous purines (primarily adenine) could be used in the synthesis of nucleotides and their nucleic acid products. A number of analogues of purine molecules, including 2, 6-diaminopurine, 6-mercaptopurine and 8-azaguanine, were synthesized and tested clinically for chemotherapeutic effects. Of these, 6-mercaptopurine in a daily dose of 2.5 mg./kg. is capable of producing remission of leukemia in approximately 40 per cent of the children and 16 per cent of the adults to whom it is administered.

In this respect, 6-mercaptopurine differs from the antifolic compounds which are ineffective in adults. Therapeutically, it is also useful in chronic myelocytic leukemia in the acute phase. As in the case of folic acid antagonists, resistance to 6-mercaptopurine devel-

ops, probably more rapidly than in the case of amethopterin. The bone marrow is also suppressed by 6-mercaptopurine and, accordingly, the white blood count must be carefully followed in patients receiving the drug. Oral lesions which develop are considerably less severe than those found after administration of the antifolic compounds.

New Compounds. It is evident that an increasing number of compounds will become available for cancer chemotherapy. An area of synthetic chemistry currently being explored is that of amino acid analogues. Studies from Lederle Laboratories and the Sloan-Kettering Institute have been made on azaserine (o-diazoacetyl-L-serine) and diazonorleucine (6-diazo-5-oxo-L-norleucine). These compounds are inhibitory to sarcomas and leukemias of the mouse. However, they induce glossitis and buccal ulcerations in at least three-quarters of the patients treated. Since the clinical trials with these compounds began less than one year ago, it is difficult to evaluate their ultimate therapeutic status. A very interesting compound, p-di (2 chloroethyl)-amino-L-phenylalanine, has been shown to inhibit both the Walker 256 rat carcinosarcoma and the Harding-Passey mouse melanoma. This substance combines the nitrogen mustard with an amino acid structure and provides a basis for the synthesis of a variety of amino acid analogues. Successful clinical tests with this compound have not been reported.

The chief difficulty in cancer chemotherapy is in the development of compounds which are selectively toxic for neoplastic tissue in comparison with the other tissues of the tumor-bearing host. It is apparent from the large number of compounds which are capable of inhibiting transplantable animal tumors that these animal tumors differ from human tumors, either in their stroma, circulatory relationships or metabolism.

If one considers the problems of development of new compounds, they may be classified as (1) development of biochemical and biological information differentiating tumors from other tissues of the host; (2) synthesis of analogue inhibitors for specific reactions which are of key importance to the tumor but of less significance to other tissues; (3) testing of the inhibitors on metabolism and function of tumors in animals; (4) pharmacological testing of the compounds for toxicity and side effects; (5) testing of the compounds on human beings with cancer; (6) synthesis of analogous compounds which are cheaper, less toxic and more effective. It is clear that increasing knowledge in each of these realms will permit the synthesis of a greater number of chemotherapeutic agents for cancer. Although there are no known curative compounds at present, the substances available today are clearly representative of early but significant achievements in the suppressive chemotherapy of cancer.—HARRIS BUSCH, M.D., Ph.D.

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Salads Should Be Treated With Respect

The accompaniment salad is an important adjunct to the meal and should be prepared with care and made as crisp and attractive as possible

JOAN M. ROCK and DORIS H. ZUMSTEG

ACCOMPANIMENT salads may or may not be served in restaurants, depending on the type of service and the price structure. But hospital food service standards require that they shall be served, which isn't always easy in busy dietary departments.

Main dish salads usually get the same careful attention that is accorded hot main courses, but accompaniment salads are a different story; the small side-dish salad is likely to be lost in the shuffle.

Certain attributes of all salads are true of accompaniment salads. The first check list that follows is a reminder of the facts pertinent to *all* salads and the second includes several additional factors which are relevant to accompaniment salads.

ALL SALADS

1. Salad greens should be thoroughly cleaned, "picked over" and then dried. Salad dressing will not combine with wet greens. Where practical, salad greens such as lettuce and chicory should be broken rather than cut.

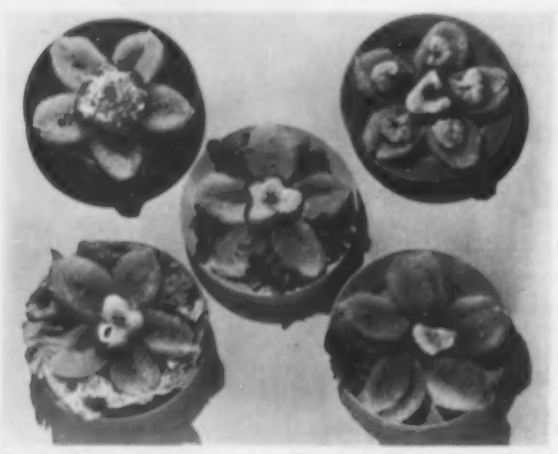
2. Salad greens must be chilled and crisp. Where possible, all other ingredients should be chilled, too. This applies to plates and salad bowls. Under no circumstance should they be warm from the dishwasher.

3. Greens should never extend beyond the edge of the plate.

4. Color, flavor, form and texture contrast should be observed in salad ingredients.

5. Canned products should be used frequently for nutritional value as well as reduced food and labor costs. Canned fruits and vegetables and some fish products must be carefully drained, and the liquids saved for other uses.

6. To restore flavor freshness lost in cutting, shredding and mixing, monosodium glutamate should be used in all but sweet salads. In green salads, monosodium glutamate, along with other seasonings, is tossed lightly before dressing is added, even though the dressing also properly contains glutamate. When used in salad mixes,



To the basic canned or fresh grapefruit can be added any salad ingredient for a tasty side salad: greens, coleslaw, shrimp, fruit, vegetables, meat or fish mixture.

Three different accompaniment salads offered here are: (back) a wedge of crisp lettuce and tomatoes; (left) green bean and anchovy; (right) pear and crushed pineapple.

it serves to balance flavor and emphasize ingredient identity.

7. Unless the kitchen boasts excellent refrigeration facilities, salads should be prepared as close to serving time as practical. It is better to reduce variety and follow proper salad making procedure. In some cases, it may be practical to increase the number of shelves in the refrigerator during salad season, in order to accommodate more salads and plates to be chilled. Adjustable shelves set 8 inches apart usually will serve well.

8. Except for marinating purposes, dressing should not be added to salads until serving time.

ACCOMPANIMENT SALADS

1. Just because they "go with" the meal, these salads should not be treated like step-children. They should be prepared and stored as carefully as are all other menu items.

2. Where a choice of accompaniment salad is offered, one green salad and one fruit, vegetable, fish or combination salad is usually a satisfactory menu pattern.

3. The salads should be planned in relation to the entire meal, not as individual courses. (For example, where salads for private patients are sent from a special diet kitchen and the main meal from another, there must be close coordination.) On the day when a nonmeat item like a vegetable casserole or macaroni and cheese are featured as the main dish, a shredded meat or distinctive fish salad, such as sardine with marinated tomato or gay pink shrimp and pineapple spear, would be welcome side salads.

4. The salads should not be too big, but they should be big enough that they are not a waste of time to prepare. They should definitely add character to the meal. The right sort and size of accompaniment salads can cut down the required portion size of the main dish, which is not to be overlooked from the standpoint of the budget.

SALAD DRESSINGS

Mayonnaise and French dressing will be standard in any salad department, for use "as is" and varied to suit the individual situation. For example, the addition of chopped egg, chives, sour cream, pimientos, olives, or a touch of mustard, curry powder, tabasco, celery seeds, or caraway seeds can do much to individualize salad dressings.

Home-size bottles of specialized dressings are sometimes the answer to perfect salad dressing without excessive expense or cumbersome inventory. This is true for the delicious items available for special diet use, too.

(*Continued on Page* 116)

RECIPES FOR TWO ACCOMPANIMENT SALADS AND SALAD DRESSINGS

Frozen Fruit Salad

Yield: 48 ⅓ Cup or 4 Ounce Servings

- 9 envelopes (2¼ oz.) unflavored gelatin
- 4½ cups cold water
- 4½ cups boiling water
- 2 cups lemon juice
- 2 cups sugar
- 1 Tbsp. salt
- Few drops yellow food coloring
- *9 cups diced fruits**
- 1½ cups mayonnaise
- 1½ pts. chilled whipping cream

Soften gelatin in cold water. Dissolve in boiling water. Stir in lemon juice, sugar, and salt until sugar dissolves. Add few drops yellow food coloring to make a light yellow color. Chill to unbeaten egg white consistency. Fold in fruits and mayonnaise. Whip cream until stiff; fold in carefully. Pour into 48 individual ⅓ cup molds, or pan, 18 by 12 by 2 inches, or two pans, 13 by 9½ by 2 inches. Freeze until firm. Unmold individual molds, or cut into 48 squares or oblongs for serving. Serve on crisp lettuce garnished with mayonnaise or cooked salad dressing.

*Use a combination of well drained canned fruit cocktail, or canned or fresh fruits.
**If fresh or frozen pineapple, sirup or juice is used, boil 2 minutes before combining with gelatin.

Tomato French Dressing

Yield: 3½ Quarts

- ⅔ cup sugar
- 3 Tbsps. dry mustard
- 2 Tbsps. salt
- 2 Tbsps. paprika
- 1 Tbsp. black pepper
- 1 tsp. monosodium glutamate
- 1 can (3 lb. 3 oz. size) canned concentrated tomato soup
- 3 cups salad oil
- 3 cups vinegar
- ⅔ cup minced onion (optional)

Mix dry ingredients thoroughly. Combine with soup, oil, vinegar and onion. Blend well.

Store in refrigerator until ready to use. Shake well before serving.

Hot Potato Salad

Yield: About 8 Quarts — *Servings: 50 5 Ounce Portions*

- 3 cups finely chopped onions
- 6 qts. thinly sliced cooked potatoes
- ½ cup minced parsley
- 3 cups cider vinegar
- 1 cup hot water
- 2 Tbsps. monosodium glutamate
- 1 Tbsp. sugar
- 4 eggs, slightly beaten
- 1⅓ cup salad oil
- 2 Tbsps. salt
- Pepper

Combine onions, potatoes and parsley. Combine vinegar and water, heat to boiling. Add sugar, stir until dissolved. Add hot mixture slowly to egg. Add salad oil, salt, pepper and monosodium glutamate. Beat vigorously with a rotary beater until well blended. Pour over potato mixture; stir with fork until thoroughly mixed. Heat gently or let stand in warm place 10 to 15 minutes.

Florida Low-Calorie French Dressing

Yield: 4 Quarts. One Tablespoon Contains 25 Calories

- 3 qts. Florida grapefruit juice, unsweetened, canned or reconstituted frozen juice
- ½ cup cornstarch
- 1½ cups salad oil
- 2½ Tbsps. salt
- 6 Tbsps. sugar
- 1 Tbsp. paprika
- 1 Tbsp. dry mustard
- 1 Tbsp. tabasco
- 3 cups ketchup
- 4 cloves garlic (optional)

Blend 3 cups of the grapefruit juice and cornstarch in saucepan. Cook over low heat, stirring constantly until thickened. Remove from heat; stir in remaining grapefruit juice.

Combine remaining ingredients except garlic. Add grapefruit mixture and beat until blended. Add garlic.

Shake or stir before serving. Store covered in refrigerator.

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SIDE-DISH SALAD

1. Coleslaw made with Florida boiled dressing.
2. Cabbage, red cabbage, and canned shredded pineapple.
3. Cabbage, with red apple, orange sections, raisins and chopped almonds.
4. Cabbage, canned grapefruit sections, chopped peanuts and pimientos.
5. Cabbage, shredded carrots and diced cheese.
6. Green beans, celery, frankfurter circles and snipped green onions, marinated.
7. Julienne, diced or sliced beets with caraway seeds and chopped egg.
8. Orange, grapefruit and watercress.
9. Spiced peach, cottage cheese and chicory.
10. Tomatoes, celery curls, sliced radishes, onion rings or scallions with tomato French dressing.
11. Cucumbers in cream dressing.
12. Macaroni, celery, radishes, parsley, scallions with tomato French dressing. (This is very good with meat loaf.)

GREEN SALADS

13. Romaine, escarole and endive.
14. Chopped raw spinach, crumbled crisp bacon, chopped eggs, French dressing.
15. Iceberg lettuce, watercress and chicory.

Above: Colorful, crisp fresh vegetable garnishes brighten any salad plate or serve as side salad by themselves. Below: An important aid to keeping salads crisp is a refrigerated cabinet and serving counter.

FRUIT SALADS

1. Peach and cream or cottage cheese, with pineapple boiled dressing.
2. Peach and grated cheddar cheese with cranberry dressing or cranberry and orange relish combined with the mayonnaise.
3. Avocado and canned or fresh grapefruit sections.
4. Apple, celery and cubes of canned cranberry jelly.
5. Spiced pear, cream cheese and chopped watercress.
6. Sliced orange and apple, whole, seedless grapes.
7. Orange and grapefruit sections, melon balls or cubes (fresh, canned or frozen).
8. Orange, cabbage and green pepper slaw.
9. Pear half and jelly or cottage cheese and ginger or julienne carrots and nuts.
10. Pineapple and cream cheese or cabbage slaw or prune-plum and cottage cheese.
11. Prunes, cottage cheese and nuts or chopped celery and peanut butter.
12. Banana, canned Bing cherries and orange.
13. Fresh pineapple and strawberries or grapes.
14. Avocado and pineapple.
15. Apple, orange, banana and berries.

Frozen salad is always a conversation piece and is certain to add interest to patient and staff meals and help keep diners in the right frame of mind. Frozen fruit side salads sometimes may serve as dessert for patients.

MOLDED SALADS

Glistening gelatin salads are handsome when individually molded, but equally attractive when made quite simply in hotel pans, then cut in squares, oblong or diamond shapes. In summer, particularly, it is best to chill gelatin salad mixtures overnight.

(*Continued on Page* 118)

NEW LOW-COST SPACE-SAVING URNS

provide **COFFEE...easily brewed!**
WATER...hot and plentiful!
RELIEF...from costly repairs!

SEALWELD JR.

NOW U.L. APPROVED

ELECTRICALLY HEATED: Plug in anywhere. For portable applications, urn can be filled through filler opening near top. Furnished with immersion heater, 110 volt unit rated at 2000 watts; 220 volt unit rated at 2500 watts. Also fitted with thermostat, on-off switch and two pilot lights, one indicating current supply, the other indicating when thermostat setting is reached. Equipped with urn bag and ring, 6-ft. cord and plug.

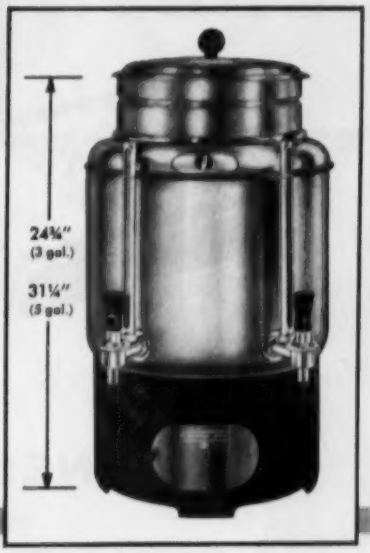
NOW A.G.A. APPROVED

GAS HEATED: Furnished with gas burner attached to base and set at correct distance from urn bottom. Equipped with urn bag and ring.

TRI-SAVER JR.

NOW U.L. AND A.G.A. APPROVED

Same as Sealweld models but furnished with permanent Tri-Saver filter which eliminates urn bags and filter paper. Available in gas and electrically heated models. Gas heated unit shown below.



• Now you, too, can brew truly delicious coffee . . . in one of these modern, low-cost urns that *provides its own hot water supply.* The Junior urns are all-welded stainless steel . . . built low and compact to facilitate brewing and cleaning . . . produced in quantity to give you outstanding value. No other popular-priced urn has ever offered so many quality features . . . features found up to now only in deluxe equipment.

Sealwelded Leakproof Seams . . . No Solder Used

Lime-proof faucet-sealing flanges and all-Sealwelded seams assure you of long service life . . . provide protection against shut-downs as well as freedom from costly repairs.

Unbreakable Permanent Stainless Steel Liner

Bottom sloped to a tangent draw-off, giving you a sanitary full-draining, easy-to-clean container.

Quick Disassembly for Cleaning and Maintenance

Installation is a simple procedure. Added savings in deliming and maintenance expenses quickly pay back the cost of the urn! Disassembles in minutes . . . without tools. Remove the faucet, lift out the liner . . . and clean!

Good Looking Too . . . That's What They'll Say!

From the sleek plastic handle on the extra-heavy polished stainless steel cover, to the scratch-resistant black skirt . . . from the conveniently built-in water filler to the self-supported, correctly positioned high-heat burner . . . your patrons will admire the streamlined good looks of the new Blickman-Built Junior coffee urns.

Here's Welcome Versatility!

In addition to brewing regular coffee . . . the Junior urns are ideal for instant coffee . . . and for iced tea too! Available now for any type of gas in two popular sizes: 3 gallons of coffee and 5 gallons of water; or 5 gallons of coffee and 8 gallons of always needed boiling water.

See your Blickman dealer, or write for descriptive folder.

Blickman-Built
FOOD SERVICE EQUIPMENT
EST. 1889

Be sure it's Blickman-Built . . . your protection against inferior substitutes!

S. BLICKMAN, INC., 1508 GREGORY AVENUE, WEEHAWKEN, N. J.

Have you seen the Coffee Brewing Institute's new booklet on how to make good coffee, "Specialty of the House?" For a copy, write us on your letterhead.

1. Fruit, chopped celery, chopped nuts molded in canned cranberry juice (unflavored gelatin).
2. Jellied beet, celery and green pepper.
3. Canned tomato aspic, cubed, on green pepper slaw.
4. Layered tomato aspic and molded cottage cheese.
5. Pineapple chunks and strawberries in lemon gelatin.
6. Canned cranberry sauce and sliced peaches.
7. Jellied applesauce, flavored with horseradish to serve with pork.
8. Orange, grapefruit and chopped nuts molded in ginger ale (unflavored gelatin).
9. Grapefruit sections in mint gelatin.
10. Jellied chopped or shredded raw vegetables.
11. Molded individual avocado ring filled with berries, shrimp or crabmeat.
12. Seafood aspic in salad gelatin.
13. Olives, raw vegetables in canned or frozen orange juice (unflavored gelatin).
14. Prune and sliced orange in lemon gelatin.
15. Fruit cocktail with juice, bananas, lime juice, in unflavored gelatin.

VEGETABLE SALADS

1. Sliced tomatoes with various dressings including chive, herb and sour cream dressings.
2. Tomatoes, cottage cheese and chives.
3. Shredded carrots, diced apples, raisins and nuts.
4. Diced beets, canned green beans and hard cooked eggs.
5. Peas, celery, shaved pickles, grated cheese.
6. Asparagus vinaigrette.
7. Asparagus and hard cooked egg.
8. Asparagus and julienne beets.
9. Tiny whole beets stuffed or trimmed with cream cheese rosettes.
10. Potato with cucumbers, capers, pecans or walnuts, julienne ham.
11. Hot potato salad — especially good with cold meat plates.
12. Small chilled plum tomatoes to eat, chilled, with a salad dressing "dip."
13. Stuffed half tomatoes (tuna, salmon, vegetable mixture, cottage cheese).
14. Chinese cabbage, dates and pineapple with Florida French dressing.
15. Stuffed celery with cheese, egg, anchovy paste or deviled ham mixture.

Go Modern...*Get* Mealpack

...*improve food service*

Food service is usually your costliest department . . . in more ways than one. MEALPACK Systems usually cut food waste 50%! Both a centralized and decentralized food, only a MEALPACK System permits complete centralization of food preparation and accurate control of tray set-ups at one main kitchen. Costly, noisy floor kitchens become new producing floor utilities and valuable bed areas. Food service is speedier, easier and costs you less . . . whether your hospital is large or small.

...*save money*

MEALPACK eliminates or supersedes many items in the kitchen and on floor pantries. It reduces personnel and inroads on nursing time. It cuts raw food costs . . . reduces wasted or uneaten food. Total benefits from *your* MEALPACK System can be $150 per-bed-per-year *or more!* For existing hospitals, MEALPACK can be installed for little or no more cost than conventional food services. For new hospitals, the same or less!

...*cut patient complaints!*

Patients frequently judge a hospital not by its medical library, but its food service! MEALPACK insures patient enthusiasm because of more palatable and nutritious meals, which include selective menus for each tray if desired. Only MEALPACK'S UNIQUE *Vacuum Sealed Protection* always serves "hot food HOT and cold foods COLD" for hours . . . so delays or adverse serving conditions don't create unsavory tasteless food. MEALPACK insures uniform, succulent food for *every* patient . . . first served or last!

MEALPACK

mealpack

hot foods hot-cold foods cold

Write us today!
Let us *show* you how Mealpack can improve food service—cut patient complaints—and save you money!

See us at Booth No. 826, A. H. A. Convention, Chicago.

MEALPACK CORPORATION · EVANSTON, ILLINOIS

Menus for September 1956

Bertha B. Ashley
Dietitian
New Britain General Hospital
New Britain, Conn.

1 Cantaloupe Poached Egg, Bacon • Chilled Tomato Juice Beef Steak Pie Chef's Salad, French Dressing Elberta Peaches Ice Box Cookies ▪ Roast Veal Red Pepper Relish Noodles, Parsley Butter Buttered Carrots Pineapple-Cherry Salad Apple Brown Betty, Lemon Sauce	**2** Orange Juice Soft Cooked Eggs, Rolls • Roast Chicken, Dressing Currant Jelly Mashed Potatoes Green Peas Lettuce Hearts, Russian Dressing Ice Cream, Chocolate Sauce • Vegetable Soup Hot Roast Beef Sandwich Cucumber Pickles Fruit Salad, Cream Dressing Maple Layer Cake	**3** Grapefruit Sections Scrambled Eggs, Rolls • Baked Smoked Ham Pineapple Ring Duchess Potatoes Buttered Lima Beans Raw Carrot Fingers Fruit Gelatin, Whipped Cream • Cream of Mushroom Soup Salad Plate: Tomato Stuffed With Chicken Salad Corn on the Cob Angel Food Cake	**4** Citrus Fruit Juice Soft Cooked Eggs, Bacon ▪ Alphabet Soup Baked Veal Chop Broiled Tomato With Cheese on Toast Potato Salad Stewed Apples Cookies ▪ Spiced Seckel Pears Roast Leg of Lamb Baked Potato Croquettes Buttered Peas, Carrots Melon Salad Baked Rice Custard	**5** Peaches Poached Eggs, Sweet Rolls • Consommé Madrilene Chicken à la King Fiesta Coleslaw Corn Muffins Purple Plums Cookies ▪ Roast Beef Red Pepper Relish Whipped Potatoes Buttered String Beans Grapefruit Sections- Onion Ring Salad Chocolate Chiffon Pie	**6** Sliced Bananas Scrambled Eggs, Bacon ▪ Cream of Celery Soup Open Sandwich: Sliced Ham, Lettuce, Tomato, Pickles on Rye Bread Fruit Cup Mocha Cake Squares • Chilled Tomato Juice Meat Loaf, Mushroom Sauce Escalloped Potatoes Stewed Fresh Corn Jellied Sunshine Salad Ice Cream With Strawberry Sauce
7 Frozen Orange Juice Coddled Eggs, Muffins • Clam and Tomato Bouillon Baked Macaroni, Cheese Shrimp and Celery Sticks, Cocktail Sauce Prune Whip With Custard Sauce ▪ Pineapple Juice Fried Filet of Haddock, Tartare Sauce Baked Idaho Potatoes Stewed Tomato Tossed Green Salad Peach Cobbler	**8** Honeydew Melon Canadian Bacon, Rolls • Chicken Soup Hamburgers in Rolls Ketchup Potato Chips Tomato Salad, 1000 Is. Dressing Vanilla Pudding With Meringue ▪ Cube Veal Steak Brown Gravy Mashed Potatoes Buttered Spinach Fresh Fruit Cup, Brownies	**9** Fresh Peaches Soft Cooked Eggs, Buns • Spiced Watermelon Roast Turkey, Dressing Oven Brown Potatoes Cauliflower Shredded Lettuce, Roquefort Dressing Maple Ripple Ice Cream • Beef Bouillon Tuna Fish Casserole Frenched Green Beans Apricot-Cottage Cheese Salad Ginger Drop Cookies	**10** Frozen Orange Juice Poached Egg, Bacon ▪ Chopped Meat Pastry Roll, Jardiniere Sauce Spiced Peach Half Vegetable Salad Bowl, French Dressing Melon Cup, Lime Wedges • Turkey Noodle Soup Pot Roast of Beef Boiled Potatoes, Parsley Butter Glazed Carrots Coleslaw Apple Pie, Cheese	**11** Sliced Oranges Scrambled Eggs, Muffins • Vegetable Soup Chicken Salad Sandwich Sliced Tomato Succotash Lemon Sponge Pudding • Grilled Ham Sliced Pineapple Potatoes au Gratin Baked Squash Celery Hearts Orange Chiffon Cake	**12** Frozen Orange Juice French Toast, Maple Sirup • Cream of Potato Soup Breaded Veal Cutlet Cinnamon Applesauce Buttered Peas Tomato-Grapefruit Salad Fresh Grapes • Chopped Sirloin Steak Fresh Mushroom Sauce Mashed Potatoes Buttered Beets Pear-Bing Cherry Salad Peach Shortcake
13 Melon Wedges Poached Eggs, Rolls • Chicken Gumbo Soup Cube Beef, Noodle Casserole Pimiento Wax Beans Fruit Salad Date Nut Squares • Cranberry Sauce Broiled Chicken, Gravy Buttered Rice Broccoli, Cheese Sauce Butterfly Salad Raspberry Sherbet Lady Fingers	**14** Stewed Prunes Scrambled Eggs, Muffins • Apricot, Orange Juice Grilled Tuna Cheeseburger Buttered Peas, Carrots Chef's Salad Molded Farina Pudding, Peach Sauce • Poached Codfish Steak Hash Browned Potatoes Broiled Tomato, Buttered Crumbs Perfection Salad Butterscotch Meringue Pie	**15** Citrus Fruit Juice Soft Cooked Egg, Bacon • Split Pea Soup Hot Sliced Corned Beef Buttered Spinach Banana-Mandarin Orange Salad Marble Cake • Cranberry Juice Shepherd's Pie (Potato Crust) Parslied Carrots Pear-Cottage Cheese Salad Vanilla Pudding, Cream	**16** Frozen Orange Juice Poached Egg, Corn Muffins • Tomato Juice Cocktail Roast Beef Whipped Potatoes Corn on Cob Celery, Carrot Fingers Chocolate Nut Sundae • Sliced Ham, Relish With Pickle Baked Macaroni, Cheese Coleslaw Fruit Cup, Cookies	**17** Fresh Peach Scrambled Eggs, Bacon • Scotch Broth Hamburgers in Roll Ketchup, Potato Salad Melon Wedge • Chicken Fricassee Candied Sweet Potatoes Buttered Lima Beans Lettuce Hearts, Chiffonade Dressing Lemon Sherbet	**18** Stewed Fresh Apples Canadian Bacon, Roll • Cream of Corn Soup Veal Cube Steak Buttered Noodles, Parmesan Cheese Wilted Spinach, Dutch Sauce Orange-Banana Cup • Spiced Seckel Pear Meat Loaf, Brown Gravy Baked Idaho Potato Buttered Beets Stuffed Celery Hearts Cherry Pie
19 Orange Juice Poached Eggs, Sausage • Vegetable Soup Cold Plate: Cold Sliced Ham, Deviled Egg, Sliced Tomato, Lettuce Biscuit, Currant Jelly Baked Apple • Pepper Relish Roast Lamb Buttered Rice, Green Peas Apricot-Peanut Butter Salad Chocolate Ice Cream, Marshmallow Mint Sauce	**20** Sliced Peaches Eggs, Frizzled Beef • Fruit Juice Cocktail Broiled Chicken, Cream Gravy Potato Croquettes Cabbage, Apple Slaw Coffee Spanish Cream • Pot Roast of Beef Oven Brown Potatoes Mixed Vegetables Molded Jellied Fruit Salad Boston Cream Pie	**21** Stewed Figs With Lemon Soft Cooked Eggs, Muffins • Clam Bisque Lettuce, Tomato, Cheese Sandwich, Pickle Potato Chips Green String Beans Frosted Angel Cake Wedge • Baked Halibut, Egg Sauce Parslied Potatoes Spinach, Chopped Mushrooms Pineapple-Cottage Cheese Salad Lemon Meringue Tart	**22** Frozen Orange Juice French Toast, Sirup, Bacon • Minted Grapefruit Sections Individual Beef Stew With Biscuit Topping Stuffed Prune Salad Maple Nut Ice Cream • Baked Veal Birds, Tomato Sauce Escalloped Potatoes Cauliflower, Buttered Crumbs Chef's Salad Fresh Pineapple, Cupcake	**23** Melon Wedge Scrambled Eggs, Buns • Roast Chicken, Dressing Buttered Rice Baked Squash Filled With Peas Jellied Cranberry Salad Ice Cream Cake Roll, Butterscotch Sauce ▪ Barley Soup Cinnamon Applesauce Canadian Bacon, Cheese Soufflé Sliced Tomato Salad Cottage Pudding, Cherry Sauce	**24** Tomato Juice Poached Eggs, Muffins • Beef Bouillon Veal Fricassee on Chinese Noodles Pimiento String Beans Waldorf Salad Gingersnap Ice Box Cake • Small Steak Duchess Potatoes Parslied Carrots Chinese Cabbage With 1000 Is. Dressing Frozen Peaches, Cookies
25 Apricot, Prune Compote Coddled Egg, Bacon • Chicken Noodle Soup Veal Chops Broiled Tomato, Buttered Crumbs Escalloped Corn Banana Cream Pie • Baked Stuffed Breast of Lamb Boiled Potatoes, Parslied Butter Harvard Beets Lettuce Hearts, With Roquefort Dressing Butter Pecan Ice Cream	**26** Orange Juice Scrambled Eggs, Toast • Apple Cider Chicken à la King Corn Bread Fresh Fruit Salad Butterscotch Nut Cake • Corn Relish Roast Beef Whipped Potatoes Stewed Tomatoes Celery Hearts Grape Gelatin, Cream	**27** Sliced Banana in Juice Poached Eggs, Bacon • Oxtail Soup Sliced Ham Shortcake Asparagus Spears, Pimientoes Grapefruit-Green Pepper Salad Tapioca Pudding, Shadow Topping • Swedish Meat Balls on Buttered Noodles Crusty Rolls Green String Beans Apricot-Gelatin Salad Apple Crumb Pie	**28** Citrus Fruit Juice Soft Cooked Eggs, Rolls • Purée of Pea Soup Seafood Newburg Potato Chips Tomato Stuffed With Marinated Vegetables Fresh Grapes, Cheese, Crackers • Salmon Loaf Fresh Mushroom Caps Baked Idaho Potatoes Buttered Peas Coleslaw Pineapple Layer Cake	**29** Baked Apple Scrambled Eggs, Bacon • Vegetable Soup Mock Drum Sticks, Gravy Buttered Mixed Vegetables Potato Salad Chocolate Pat Ice Cream • Chilled Tomato Juice Smothered Liver Buttered Rice Green Lima Beans Raw Carrot Fingers on Lettuce Peach Melba	**30** Orange Sections Poached Eggs, Sweet Roll • Chicken Rice Soup Baked Ham, Champagne Sauce Sweet Potato Puff Cabbage in Cream Hawaiian Salad Lemon Meringue Pie • Olives Individual Chicken Pie Green Salad Bowl With Julienne Vegetables Fruit Cup, Oatmeal Cookies

Ready-to-eat or cooked cereals served on all breakfast menus.

Why risk your investment in costly produce by using an ordinary salad dressing?

For only 1/10¢ more per serving you can use top quality

Miracle Whip

You use choice tomatoes in your salads so why risk spoiling the salad *and* customer dissatisfaction by using just any salad dressing. For only 1/10¢ more per serving you can dress your salads with Miracle Whip . . . the nation's finest!

Here's what you get when you use Miracle Whip—

• *For only 1/10¢ more*—you get a dressing that's creamy-thick, rich and full-bodied . . . that won't water off or break down in use!

• *For only 1/10¢ more*—you get a dressing that keeps salads fresh all day long . . . with no discoloration!

• ***For only 1/10¢ more—you get a dressing that your customers themselves use 20 to 1 over other brands!***

Kraft Foods Company
500 Peshtigo Court, Chicago 90, Ill.

The Nation's Taste is Your Best Buying Guide

Paint Performance, First Class

Select a specialized paint for the job to be done.

Treat the paint well from the time you get it until you apply it.

WALLACE A. MOYLE
Supervisor of Buildings and Grounds, University of Connecticut

WELL designed paints are carefully engineered and tested materials. When used to meet conditions for which they are designed, they will perform within rather definite and measurable limits. When employed to meet conditions that exceed their design, they will probably "fail."

The architect designs the columns, girders and other parts of a building surely and completely to withstand not only the floor loads but *all* stresses. He allows a factor of safety. This having been done, no one is permitted to tamper with his design and the building stands on through the years. It is now time to treat paint systems in the same way—to design them to more than meet all the conditions they will encounter and then hold rigidly to the paint system needed.

These conclusions emerge from the mass of information accumulating as studies continue into the subject of selecting and buying paints.* They emphasize the need for understanding the capabilities and characteristics of each material and for complying with the manufacturer's, not the salesman's, instructions for handling and using it.

ESTABLISH FUNDAMENTAL ELEMENTS

As research and experiments have progressed several fundamental elements have been established. The most important of these seem to be: (1) the need for establishment of practical painting standards; (2) determination of a material's characteristics to support each standard; (3) selection of materials having proven formulations and performance; (4) proper handling and use of materials; (5) proper workmanship.

The painting crew at the University of Connecticut is composed of an average group of skilled painters. Each of its members does a creditable day-in-and-day-out job. Some are more experienced than others. A few can be classified as master painters in that they understand the mixing of colors, the inherent properties of most commonly used paints, their components and supplementary materials, the preparation and suitability of surfaces and equipment. Others do a very satisfactory job of preparation and application but have only a general understanding of the other elements of the painting trade.

All members of the crew at the University of Connecticut have responded favorably to the information presented on methods, materials and objectives of the experiments undertaken during the last eight years. On-the-job instruction has included the "what, when, where, why and how" of each material used, much of which is not ordinarily explained to institutional painters. Results indicate rather conclusively that even a little interesting instruction pays obvious dividends in better performance of materials and better workmanship. When substantially the entire problem is discussed, the tradesman invariably can be relied upon to take a dependable part in its solution.

Entirely aside from inspection of jobs, it is vital that the painter in hospital life have a real conscience and that he use it. He should feel that the institution is just as truly his as it is that of any member of the hospital staff.

Materials of the highest order can be rendered quickly inferior by improper handling, use and application. Relatively poorer items may give a satisfactory performance with careful and intelligent use. Since Items 1, 2 and 3 were discussed in detail in previous issues, they will not be reviewed here. The purpose of this article is to present some observations concerning the proper handling and use of paints and proper workmanship.

NO ONE PAINT FULFILLS ALL NEEDS

As yet no one paint will fulfill all painting needs, but there are an appreciable number that will meet specific requirements. A large number of well known manufacturers allocate sizable sums of money annually for design, laboratory and field testing, and marketing of carefully and soundly engineered products. They know what each of their products will accomplish and the conditions under which each can be successfully used. They know how each material must be handled and what the results of mishandling are likely to be. They can describe quite well the manner in which each item must be applied and the condition of surfaces to which it will properly adhere.

It may be well to define the terms "handling" and "use." By "handling" is meant the manner in which the material is treated from the time of receipt by the user until its application. By "use" is meant the selection

*Moyle, Wallace A.: Selecting and Buying Paint, Mod. Hosp. 84:73, 126 (April, May) 1956.

Let's not clean away dollars and man-hours with costly, inadequate floor care

MECHANIZE *your floor-cleaning with a* COMBINATION SCRUBBER-VAC!

(Powder Dispenser and Level Cable Wind are accessories)

Wherever *combination-machine-scrubbing* is the practical solution to the floor-cleaning problem, any lesser, slower method is wasteful of money and manpower. A *Combination Scrubber-Vac* applies the cleanser, scrubs, flushes if required, and picks up (damp-dries the floor)—*all in one operation!* Maintenance men like the convenience of working with this single unit . . . the thoroughness with which it cleans . . . and the features that make the machine simple to operate. It's *self-propelled,* and has a *positive* clutch. There are no switches to set for *fast* or *slow* — slight pressure of the hand on clutch lever adjusts speed to desired rate. The powerful vac performs quietly. Cable reel is self-winding. *Model 213P Scrubber-Vac* shown at left, for heavy duty scrubbing of large-area floors, has a 26-inch brush spread. Cleans up to 8,750 sq. ft. per hour (and more in some cases), depending upon condition of the floors, congestion, et cetera.

Finnell makes *Scrubber-Vac Machines* in a full range of sizes—for small, vast, and intermediate operations. From this complete line, you can choose the size that's exactly right for *your* job (no need to *over-buy* or *under-buy*). It's also good to know that you can lease or purchase a *Scrubber-Vac,* and that *a Finnell Floor Specialist and Engineer is nearby* to help train your maintenance operators in the proper use of the machine...to recommend cleaning schedules for most effectual care . . . and to make periodic check-ups. For demonstration, consultation, or literature, phone or write nearest *Finnell Branch* or Finnell System, Inc., 1408 East Street, Elkhart, Indiana. Branch Offices in all principal cities of the United States and Canada.

FINNELL SYSTEM, INC.

Originators of Power Scrubbing and Polishing Machines

Everything for Floor Care — FINNELL

BRANCHES IN ALL PRINCIPAL CITIES

of the material designed to perform properly during and after application. Proper workmanship includes preparation of the surfaces as well as good mechanics in application.

It is difficult to overstress this. The paint goes onto a surface. The result depends on both painter and surface. Few painters will paint over wet wood or cement or some equally obvious error, but many will and do paint over surfaces where the old paint is in the process of detaching itself from the surface. They cover this up. It is absolutely vital to paint only over a sound surface. By and large, more time in preparation of surface is a current need.

If paint could be applied at the point of manufacture, that is, just as soon as it comes out of the final manufacturing operation, the amount of handling would be reduced to a minimum. The longer the elapsed time between the final mixing and its use, the greater the handling required.

Paints in storage are subject to a progressive separation of components resulting in settlement of pigments and the tendency to form "skins" over the surface. Some are more prone to these than others. Storage places should be dry and warm. If shipments can be made directly from the factory to the final user, it is probable the time in vendors' storage will be at a minimum. More important, however, is the necessity for using first materials that have been longest in local storage. The objective should be to consume all paints in storage not later than six months after receipt. This will substantially reduce the tendency of pigments to settle and surface skins to form.

SAVINGS MAY BE DISSIPATED

After this length of time the apparent initial saving gained through quantity purchases may be dissipated by the greater cost of redispersing pigments and removing skins and otherwise properly preparing the paint for use. Under some conditions it may be necessary, in addition to agitating or stirring, to strain the paint to assure complete removal of skins and undispersed pigments.

This condition may be mitigated to some extent by careful storage procedures. Inexpensive mechanical agitators are available that redisperse the contents of a container by shaking. It might be well to consider such a piece of equipment and require any item not issued from stock at the end of six months to be agitated and returned to the shelf. As a matter of fact, it will help the man on the job if all paint is given a thorough "shaking" in the warehouse at the time of issue.

When the container is opened on the job, the first operation is to remove any skins that have formed. The purchasing requirement that "any skins that have formed be removable in one unbroken sheet" is important. If the skin breaks and all of it is not removed, it may be necessary to strain the entire contents of the container to remove the small pieces. This takes time and reduces the designed formulation to the extent of material remaining in the strainers. It may be necessary also to strain the material if the settled pigments clot and if these clots are not broken up and thoroughly mixed.

The next step in preparation is the thorough redispersion of settled components. This is a very necessary operation. Unless the pigments that have

settled are thoroughly redispersed, the material will not have the characteristics it is designed to have. This is the reason for the purchasing requirement "that all settlement be soft and easily redispersible." It is particularly important when 5 or 10 gallon containers are purchased and where material is poured into gallon cans for ease of handling on the job. Each time the small can is to be refilled, the material in the larger container must be stirred to make sure of proper mixing. Too, the material in the small can should be stirred to blend the old mixture with the new.

Containers should be covered when not in actual use. This is particularly important at night and in warm temperatures to reduce evaporation of the thinner and to reduce the formation of skins.

Proper thinning cannot be too strongly stressed. The purchasing description for the paint should contain the requirement that the manufacturer's label on each container shall include instructions for thinning, and care must be taken to see that these instructions are followed by painters. The amount of thinner being added must be measured and not guessed at. The practice of allowing a painter to thin a paint until it meets his "feel" will result in an uneven performance and may destroy the design of the product. Insist that the thinner when added is in measured quantities and does not exceed the manufacturer's instructions unless he is consulted first.

ANALYZE TABLE

Analyze the table on page 126 for it indicates how easy it is to reduce or to destroy the design of a good product by failure to understand and control overthinning. The net result is summarized in the column "% Loss in Durability, Hiding and Performance" and varies from 25 to 50 per cent. This may explain the failure of many reputable paints; it emphasizes the necessity for complying with the manufacturer's instructions to assure proper performance of his products. Too much thinning impairs a paint in the following ways: sealing ability, flatting, lack of hiding power, bleeding, sagging, flashing of a flat paint over a priming coat, mottling, breaking over sharp edges, and, in some cases, need for an additional coat.

Even if a paint can take more thinning than manufacturer's instructions indicate, the painting standard may be violated if it is thinned beyond a certain point. For example, if it is decided the dry paint film required safely to support a painting standard is that film resulting when 500 square feet per gallon of surface is covered, any appreciable variation from this figure will change the standard, and the purpose for establishing the standard will have been reduced or negated. Under certain conditions paints can be extended to give initial coverage over a greater area, but this results in a reduced dry film that may not be expected reliably to give the service that the standard is designed to achieve. Remember, too, that you establish the standard. The manufacturer supplies the material to support that standard.

If the standard is reasonable it will have been concurred in by several, but certainly not all, of the manufacturers with whom it was discussed at the time it was established. If it is found that several reputable manufacturers concur, you have established several

For Genuine Beauty . . . specify new "TERRAZZO" pattern

There's more vinyl in every tile of *Bolta Floor*... stays beautiful longer ...with or without wax!

■

Also available in 22 marbleized and solid colors!

Here is the rich, authentic beauty of old-world terrazzo—in wonderful, modern, "soft-to-the-step" Bolta-Floor vinyl tile! Bolta-Floor is a high-content, *homogeneous* vinyl floor tile that assures longest wear and lowest possible maintenance costs. Bolta-Floor will keep its gleaming beauty through *years* of hard use!

"Terrazzo" Bolta-Floor is produced in 15 beautiful decorator colors—and in 6 x 6, 9 x 9, 12 x 12 and 18 x 18 tile sizes (⅛" or .080" gauge).

Don't settle for less! Get the *genuine* beauty of new Bolta-Floor "Terrazzo."

For samples write:

THE GENERAL TIRE & RUBBER COMPANY

FLOORING DIVISION • AKRON 9, OHIO

What Happens to Paint When Amount of Thinning Is Excessive

Paint Products	% Solids of Volume	With Normal Thinning Label Directions: Storm Viscos. KU	With Normal Thinning Label Directions: Spread Sq. Ft. per Gal.	With Normal Thinning Label Directions: Film at This Rate in Mils	Effect Thinning With Extra Pint of Min. Spirits to Gal.: Storm Viscos. KU	Effect Thinning With Extra Pint of Min. Spirits to Gal.: Spread Sq. Ft. per Gal.	Effect Thinning With Extra Pint of Min. Spirits to Gal.: Film at This Rate in Mils	% Loss in Durability, Hiding and Performance
House paint undercoat.....	68	88	450	2.4	65	650	1.7	40
House paint finish coat.....	76	93	550	2.2	65	800	1.5	40
One-coat house paint (heavy)..	83	95	400	3.9	65	750	2.0	40
One-coat house paint*.....	83	95	550	2.7	65	750	2.0	30
Floor and deck enamel	40	75	600	1.1	55	800	0.8	25
Trim and shutter.....	50	82	600	1.4	60	800	1.0	35
Enamel undercoat.....	49	82	550	1.4	55	850	0.9	50
Nonyellowing enamel	58	78	550	1.7	60	800	1.2	40
Plaster primer and sealer.....	48	100	550	1.4	60	850	0.9	50
Velours flat wall paint	50	90	600	1.4	60	800	1.0	30
Zinc dust primer for metal.....	70	68	500	2.2	55	850	1.3	40
One-coat semi-gloss enamel...	52	77	500	1.7	60	800	1.1	40
Spar varnish.....	40	"E"	600	1.1	"A"	800	0.8	25

*This paint is unique in design in that it can be applied in a single brush application to yield a film thickness of up to 4 mils without sagging. It will dry through at 4 mils.

sources for materials that can be relied upon to support the standard. It is quite possible, if not quite probable, that the occasional objection to such a standard arises from offerings of inferior or untested products.

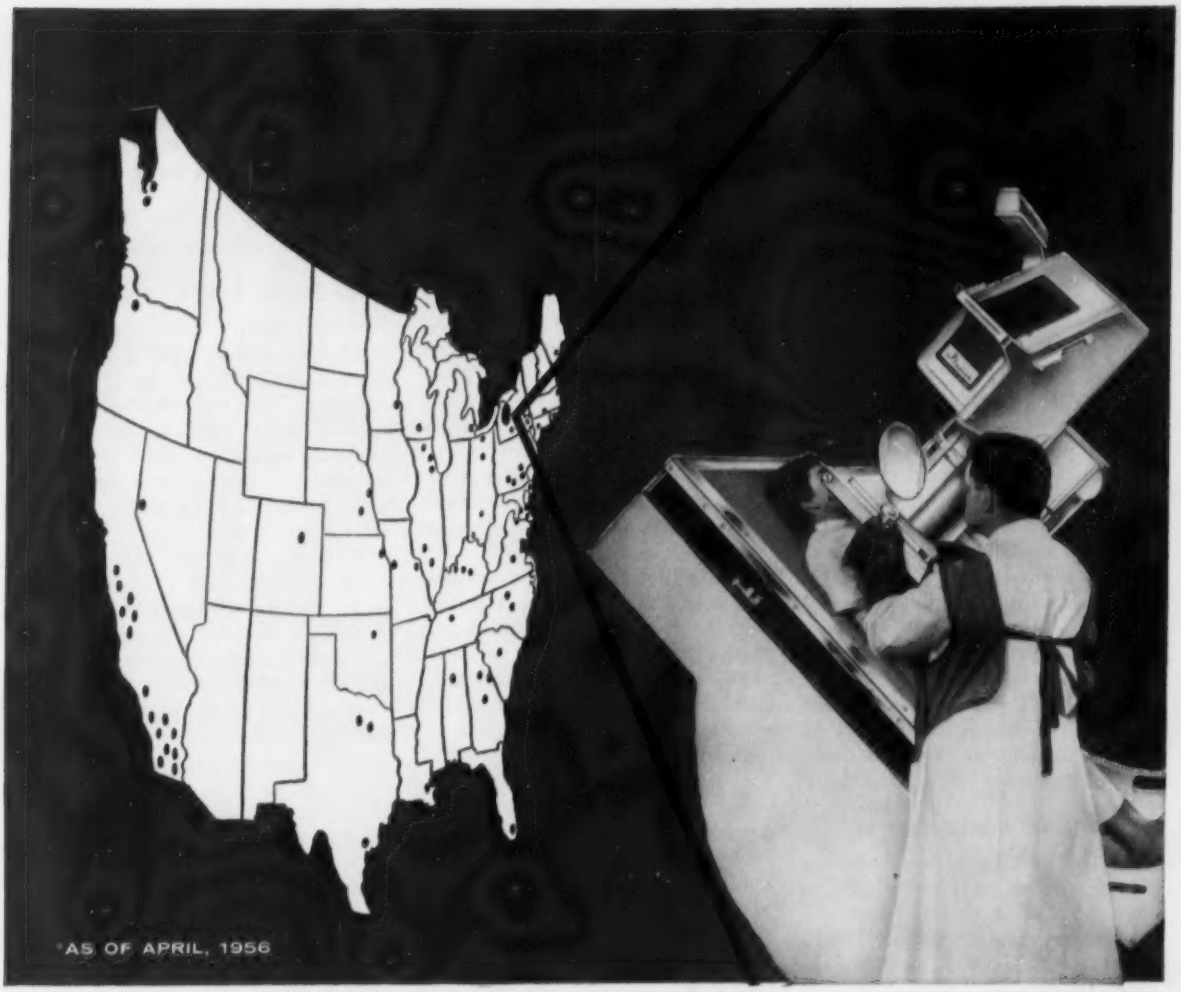
In this and previous discussions reference has been made to film thickness, which is an important element in the "life expectancy" of a paint. The dry film is that part of the paint that remains on the surface after volatile components have evaporated. The thickness of the dry film of any paint can be calculated as follows. There are 231 cubic inches in a gallon. The thickness of the wet film in mils is $\frac{231000}{\text{sq. in. covered}}$. A paint that will cover 500 square feet will provide $\frac{231000}{500 \text{ sq. ft.} \times 144 \text{ sq. in.}} = \frac{231000}{72000}$ = 3.2 mils. The dry mils thickness then is the wet film thickness x $\frac{\%\text{ of solids}}{100}$ or, for a paint having 68% total solids, 3.2 mils x $\frac{68}{100} = \frac{2176}{100}$ = 2.176 mils or 0.002176 inch.

If paints are used as designed, and in accordance with the requirements of the standard they have been purchased to support, they can be used as a ready measurement of work efficiency. For example, if a one-coat roller applied alkyd is used at a rate of 450 square feet per gallon and if there are 50,000 square feet to be painted, the amount of paint and thinner can be quite accurately determined. It will be approximately 111 gallons to which should be added about 10 per cent for spillage, loss in mixing, and so forth, or 120 gallons of paint.

As each painter will use about 1.6 gallons per day (including preparation and painting of trim) it can be estimated that $\frac{120}{1.6}$ or 75 days of labor will be required to do the job. If three men are assigned the job it will take about one calendar month. A check on the quantity of paint used and area covered after one or two days will give a quick check as to whether or not the proper standard is being followed. A check at the end of the week can be made quickly to determine the level of performance. The whole operation can be planned in advance, production goals established, and checks quickly applied.

A word about square foot coverage as advertised by the manufacturer. It appears this is a figure established in the laboratory. While it is a true figure, it is based upon application of paint to a smooth surface black and white checkerboard card a square foot in area. The amount of paint by weight required to provide complete coverage on the card is divided into the total weight of a gallon of paint to get the coverage in square feet. This is actually a maximum figure under the best possible conditions.

The area covered per gallon will be smaller as the surface being painted is rougher. Actually the total area covered may not be appreciably less if the actual area of the exposed surface can be calculated. For example, consider a sand finished ceiling in comparison with a smooth hard finished ceiling. If the exposed surface of each granule of sand projecting below the basic plane is considered, it is obvious



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the area calculated merely by taking the product of the sides of the room is not accurate and is substantially smaller than the surfaces to be painted. It will be necessary to make allowances for rough surfaces and not to try to get the maximum coverage as calculated for a smooth hard plaster surface for other types of surfaces.

Probably the most important element of use is the selection of the proper material for the job to be done. Modern paint chemistry has produced an increasing number of "paint type" coverings to meet the many special conditions encountered in this major phase of maintenance. For example, it is now possible to apply certain materials to certain surfaces that are still moist with assurance the paint will stick. Rust inhibitors permit paints to be applied to surfaces with some rust on them with assurance that oxidation will be neutralized and the paint will "stay put." Soft paints, such as a flat lead and oil paint, obviously will not give satisfactory service if used on floors and will not be as satisfactory on interior walls that require repeated washings as will the alkyd resins and some of the newer resin emulsions.

SATISFACTORY SUBSTITUTES

On the other hand, certain modern paints such as the epoxies may be satisfactory substitutes for some of the more expensive bathroom wall coverings. The transyls, another form of vinyl chloride plastics, appear to offer a solution to the annoying problem of protecting walls at the chair rail level or of eliminating the drying and curling of calking compounds on skylights. Polyvinyl acetates, which are now beginning to appear, promise very satisfactory performance as primers and probably as exterior finish coats for cinder block, cement block, and other masonry surfaces. The use of silicones as a component of, or as a final application over, ceiling paints in showers and kitchens seems probable.

Regardless of how specialized the paint may be, it should not be used to cover up a basic structural defect. If paint is peeling on an exterior wall the fact that it may be possible to find a material that will stick is not the answer to the moisture condition originating under the exterior paint. That moisture is going somewhere. If the paint can withstand the hydrostatic pressure from within and the moisture cannot escape in that direction, it most certainly will find another outlet. Its source must be found and corrected. The statement "Save the surface and you save all" is not tenable. All you save is the surface and the appearance and for probably only a short time unless the condition is thoroughly analyzed and the cause for unsatisfactory paint performance is corrected.

Proper use of materials can be determined to a dependable degree during the establishment of painting standards. As a matter of fact, painting standards cannot be reliably established unless careful consideration is given to the surfaces to be covered and unless structural conditions involved are carefully evaluated. In determining the characteristics of materials required to support a standard, the limitations of the material must be considered as well as its design and engineering. Since this process involves discussions with several manufacturers, it is most probable the negative as well as the positive consideration will be listed and well may be included in the manufacturer's instructions for use of each material.

Finally, the item of workmanship. The proper preparation and application of the material are essential. Preparation of surfaces and application of paint to them are equally important. The craftsman who is proud of his work recognizes this and actually may spend more time on the preparatory operation. To the "dauber" painting is just "putting it on, making it look good, and hoping it will last."

MUST LEARN TO ADJUST TECHNIC

The painter must learn to adjust his technic to the material and not expect the material to be adjusted by thinning to fit his particular ideas. It is probable the same type of paints manufactured by different companies will be somewhat different. One may spread more easily than another or the lap time may be longer or shorter. One may flow better after application to smooth out brush marks. Although their viscosity numbers may be the same on the scale, one paint may sag and the other may not. It is probable, if the major characteristics are substantially the same, the long-range performance will be substantially the same.

For this reason it is preferable that the same brand of paints be used for each type of painting so that, having acquired the ability to use it, painters are not upset by having to become familiar too often with products of a different manufacture.

One interesting observation has to do with the use of paint rollers. In a large crew a more nearly standard result is obtained with rollers than if brushes are used. In many instances where surfaces are rough or porous it has been found that the roller rolls the paint "in" as well as rolling it "on."

SELECT PROPER ROLLER

As with brushes, rollers must be selected. One with too short a nap will produce small parallel ridges that, although not too obvious, will make washing rather difficult. Long nap rollers can be used effectively for chain link fences. The selection of a suitable roller is necessary to assure proper roller workmanship.

With heavy paints, such as the newer one-coat house paint, it is essential that the workman be required to use the material properly. These paints are designed to cover at a rate of 3.5 mils (0.0035 inches) to 4 mils (0.004 inches) dry film. Some of them spread easily but as the job progresses it will be discovered that coverage is at a rate of only from 325 to 375 square feet per gallon for paints rated by the manufacturer at from 500 to 550 square feet per gallon. The painter must experiment with the amount of paint he lifts out of the container on each brushful and with the amount of pressure he applies to get the tip of his brush deeper into the initial application to spread the mass rather than just move a layer of the material off the top. This is a matter of adjusting technic to material.

It is not the purpose of this discussion to present the technic of painting. Rather it is intended to indicate that if the design and engineering of paint products are known and if the limitations of each material are understood, performance can be anticipated with reasonable accuracy if the paint is selected, handled and used properly and if sound workmanship is followed in applying it.

In conclusion, the following statement is a good basis for analyzing the probable performance of any paint: If the product is a regular item of the manufacturer and has been made and marketed long enough for the manufacturer to support his claims for performance, the reasons for apparent failure of the material are more likely to be improper use and workmanship than faulty material.

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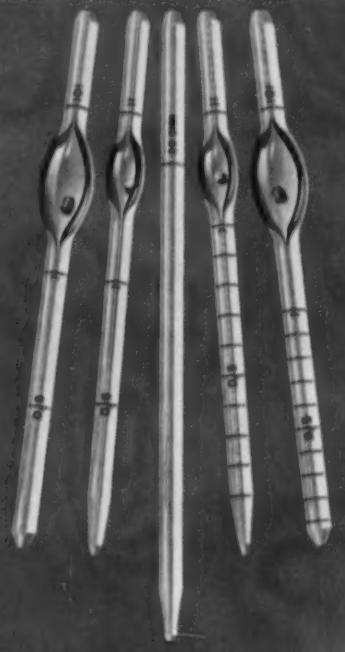

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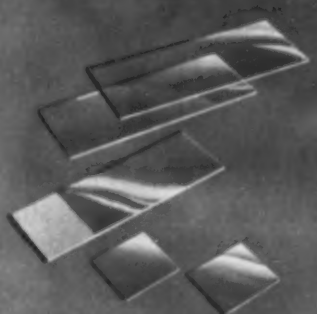

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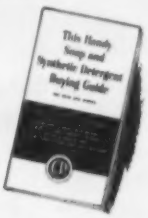

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What Good Will an Education Do?

MADGE H. SIDNEY

WHY is there such a great need for education for executive housekeepers? For the answer let's look back to the early days of hospital housekeeping. Then the housekeeper performed comparatively simple duties concentrated almost entirely on the primary function of keeping the hospital clean —duties that had been transferred from nursing together with certain technics and procedures for the housekeeper to follow.

Before long, however, the housekeeper began to accept additional responsibilities that made her realize she must broaden her scope of knowledge and learn about textiles, sanitation, linen control, floor maintenance, and laundry management. It was then that she started to teach herself, mostly by the trial and error method.

The need for education gradually became apparent and in 1930 a group of pioneer housekeepers, under the leadership of the late Margaret A. Barnes, organized the National Executive Housekeepers Association. They believed that through concerted action the organization could assist the individual member in gaining professional recognition. This was a turning point for institutional housekeeping generally and the beginning of growth and expansion for the hospital housekeeping department.

These charter members set standards according to the needs of their time and, as the housekeeping functions became more diversified and the need for education became more apparent, they utilized short courses, workshops, and institutes for executive housekeepers which were made available to them through the American Hospital Association and some universities.

In the last 15 years hospital housekeeping has advanced by leaps and bounds, far beyond normal growth. Little wonder when we consider the growth of hospitals as a whole; the shortage of nursing and other professional personnel; the introduction of new programs within the hospitals; the difference in personnel market, and the willingness of the executive housekeeper to accept greater responsibilities in order to attain full growth for her department.

During this period, the American Hospital Association and hospital administrators urged housekeepers to set up a recruitment and educational program for future housekeepers. A few farsighted individuals who recognized the lack of such a program as a future threat to the housekeeping field attempted to introduce the idea of a planned educational program on the university level for the housekeepers of tomorrow, but the majority turned a deaf ear to these leaders. Why? Were housekeepers shortsighted? Didn't they feel any sense of responsibility to

Mrs. Sidney is the director of housekeeping of Doctors Hospital, Seattle. This article was condensed from a paper presented at the executive housekeepers' section, Association of Western Hospitals, Seattle, April 1956.

Doors to Education Are Open

JENNIE I. ROWNTREE

THE purpose of this discussion is to encourage executive housekeepers to consider how specialized education can raise the position of housekeeper to that of other groups in the hospital, how it can benefit them personally, and what it would mean to hospitals if they could demand certain qualifications of their housekeepers.

Nothing except education raises prestige of people or groups. Even though executive housekeepers are given responsibilities galore, even though their salaries are excellent, unless they are educated they just don't rate. Today this education also must include some specialized work. People must know and do one thing well and be thoroughly useful. In addition, since workers today have so much leisure, they must learn how to spend their off-hours in a way that gives them satisfaction and contributes to society. Schools today are trying to overcome incompetence and to develop the conscience.

Schools are trying as never before to meet people's needs, to prepare them for good positions, and to help them to live richly.

The educational doors are all open, and the halls within are stocked with interesting things. Materials are there that will widen interests, deepen curiosity and prevent boredom, make

(*Continued on Page* 140)

Dr. Rowntree is director of the school of home economics, University of Washington. This article was condensed from a paper presented at the executive housekeepers' section of the Association of Western Hospitals, Seattle, April 1956.

the future housekeeper? Were they perhaps afraid that higher education for the future housekeeper might imperil their own jobs? Didn't they realize that the lack of such a program would eventually retard the growth of the housekeeping field? Isn't 26 years a long time for the housekeeping or any other field to exist without a progressive program for recruitment and education?

If we refuse the opportunities and security that higher education can give us, housekeepers are not advancing with the times. Soon we will start to backslide for if we cannot supply trained housekeepers to meet the demands of our hospitals today (and we admit there is a shortage of key personnel), how can we hope to provide executive housekeepers for the greater hospitals of tomorrow? Should we continue to evade the issue of education? Should we keep on saying, "The time has not yet come when a housekeeper must have a degree from a college or university in order to do a good job of institutional housekeeping. The time will come, however."?

Shouldn't we start planning today, knowing that a progressive educational program takes time to develop and it may be 10 or 15 years before our institutions benefit fully from today's planning?

Why this need for higher education? Can any lower level of education prepare the future housekeeper to cope with existing hospital housekeeping problems plus all the new situations that might arise for her in this fast changing world? We admit the need for her to study human and public relations, personnel management, psycology, physics, chemistry, bacteriology, interior decorating, textiles, economics, organization and management, accounting and budgeting. Doesn't this in itself suggest a degree course?

Our administrators want uniformly qualified housekeepers with executive as well as technical ability and these uniform qualifications mean minimum educational standards for the development of both technical skills and executive abilities.

Hospitals under skilled executive housekeepers must, can and are willing to conduct programs for the development of these skills.

Universities and other schools can provide learning opportunities which would be too costly and perhaps impossible for hospitals to provide. Other professions have learned to utilize existing educational facilities to obtain the best possible learning under the guidance of skilled teachers and to reduce the cost of education.

Do we want to open the door for future housekeepers? Do we want to direct the course of education for future housekeepers or do we want to let someone else do it?

The history of other groups has shown that if the demand is not met by the members of the profession, pressures from potential employers will tempt someone to set up a training program for personal gain.

The question is not, "Can we meet the pressures and can we direct the course of education for our profession?," but, "Will we do it?" We do not have too much time to decide.

Are we ready and willing to pool our resources of experience, and expend time and energy in the task of defining, sorting and organizing the kinds of learning experience necessary for the others to learn in a few years what many of us have spent a lifetime learning?

Our administrators, our associations, and our universities are willing to help

National Executive Housekeepers Association Passes Resolution on Education, Recruitment

FOLLOWING the Association of Western Hospitals meeting at which the papers by Mrs. Sidney, Dr. Rowntree and Miss Northrop were presented, the National Executive Housekeepers Association held its biennial congress in Los Angeles. At this congress, the association passed the following resolution designed to facilitate the establishment of college courses in executive housekeeping and the recruitment of prospective executive housekeepers.—Ed.

Whereas: The duties and responsibilities of the executive housekeeper are becoming increasingly varied and complex; and

Whereas: The demand for competent executive housekeepers has already grown beyond the capacity of the field to supply qualified persons; and

Whereas: It is essential that executive housekeepers shall have formal, academic training comparable to that available to their fellow department heads; and

Whereas: The opportunities presently available for academic training in institutional housekeeping are not adequate in number and courses are not uniform in quality.

Be it therefore resolved that: The National Executive Housekeepers Association at its 1956 biennial congress assembled in Los Angeles take the following measures to implement a positive program of education for present and future executive housekeepers and, at the same time, to recruit eligible men and women into the field:

1. An Educational Policies Commission shall be established consisting of the National Committee on Education as a coordinating committee with two subdivisions consisting of a committee on hotel housekeeping education and one on hospital housekeeping education. The president of the National Executive Housekeepers Association shall appoint the chairman of each subcommittee and an equal number of representatives from each field for the separate committees. The functions of this commission shall be:

(a) To enlist the interest of colleges and universities in establishing courses in institutional housekeeping;

(b) To work out with college officials curricula adapted to the particular needs of the executive housekeeper;

(c) To appoint two sub-chairmen (representing hotels, hospitals and other institutions) in each local chapter to work with colleges and universities in the respective areas, according to instructions and to report progress to the national chairmen at stated intervals;

(d) To recruit properly qualified college graduates and college trained, experienced homemakers into the housekeeping field; to interest college and high school counselors in directing qualified students into executive housekeeping courses where these have been established; to interest mature women with management ability in considering a career in housekeeping;

(e) To work with colleges in establishing evening extension courses that shall be open both to executive housekeepers now employed and to persons who wish to prepare for a career in executive housekeeping;

(f) To work with hospital administration, hotel management, and other institutional management in planning internships for prospective executive housekeepers who have completed the academic requirements;

(g) To enlist the aid of the American Hotel Association and the American Hospital Association in promoting the college courses and in obtaining financial aid where it is needed; and also in establishing additional refresher courses and institutes for executive housekeepers who are presently employed.

And be it further resolved: That the Educational Policies Commission appointed at this congress shall be instructed to give an annual report of progress to the members through the Neha News during the next biennium, and to make a report to the 1958 N.E.H.A. Congress.

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us, but first we must open the door by showing willingness to accept our rightful responsibility to the people who must follow in our footsteps. We, the housekeepers of today, must set the standards, plan internship programs, select the necessary courses by utilizing existing educational facilities, and finally, when we have a progressive educational program to offer the potential housekeeper, we must start recruiting.

There are many farsighted leaders in the field of housekeeping today who have been preparing the groundwork for this much needed educational program. To make this a national program, these leaders need the support and cooperation of all executive housekeepers to work and make contacts with universities and hospitals in their local communities.

Puget Sound housekeepers, for example, resolved to raise the requirement standards for executive housekeepers and, by so doing, provide our hospitals with an adequate number of educated and trained future housekeepers.

We have prepared a proposed curriculum for institutional housekeeping at the University of Washington, and a committee is currently planning a one-year inservice hospital housekeeping course for student housekeepers who will have met the proposed educational requirements. The interest shown by administrators leads us to believe that this proposed program on completion will not only be accepted but welcomed by the hospitals in our community. This is only the beginning. A planned recruitment program is next on the agenda.

We hope that housekeepers *in association* will promote similar programs, for only through the national success of such a program can we meet the needs of our institutions, make our association as purposeful as it should be to the executive housekeeper, and ensure the future of our chosen field.

Recruiting Line Forms on the Right

MARY W. NORTHROP

THERE was a program chairman who believed that dreams come true. She knew that institutions have a great deal to offer to executive housekeepers and that executive housekeepers have a great deal to offer to institutions. She knew that the supply of qualified housekeepers is not now equal to the need for them. She *dreamed* that she saw a long line of attractive and able women waiting for the door of opportunity to open and let them in, and so she wrote on her program the subject "The Line Forms on the Right."

No realist, however, believes that dreams come true of themselves, and this one will be no exception. The depression was 25 years ago, and the resulting period of low birth rate now is being felt in the reduced number of people coming into the labor market just at the time when increased population and an expanding economy have increased the number of job openings. Statistics show, moreover, that women are marrying earlier and having larger families than they did a few years ago, thus shortening their years of availability for work outside of the home. Housekeeping is a field pre-empted by women and there are not enough women available. All of the professional and executive fields for women are scraping the bottom of the same empty barrel. So, obviously, the line is not going to form on the right or anywhere else unless something is done about it. Several things can be done and housekeepers should take the initiative.

First of all, don't be afraid to like your job! The best recruiter for housekeeping is the housekeeper who radiates enthusiasm and job satisfaction, everywhere and all the time. One never knows who might pass the word along or how far one's influence may travel.

Let us imagine two conversations. The scene for each is laid first on a bus in the late afternoon, and in a living room the same evening.

FIRST CONVERSATION:

Scene 1: In a bus

HOUSEKEEPER: (Sitting down heavily beside a friendly looking woman) "Oh, what a day! I'm dead on my feet. Why does anybody stay in this business?"

FRIENDLY WOMAN: "What business are you in?"

HOUSEKEEPER: "I'm an executive housekeeper, and what a headache it is!"

FRIENDLY WOMAN: "I guess every job has its problems."

HOUSEKEEPER: "I suppose so, but ours are worse. You have to be on your feet so much, and the boss doesn't think you are anybody, and the employes you have are no good, and half the time you even have to work on Sundays. It's just dirt and problems all day long."

FRIENDLY WOMAN: "I should think you would look for another kind of job. I get off at the next corner."

Scene 2: In a living room

FRIENDLY WOMAN: (Offering a comfortable chair to a caller who has just come in) "It's nice to see you, Helen. I've been wondering about you. I heard you had left your job and were looking for something else. What are your plans?"

HELEN: "I've thought of seeing if I could get a job as a housekeeper in a school or a hospital or something. I think I would like that."

FRIENDLY WOMAN: "I would have liked that idea, too, until this after-

---

Miss Northrop is chief dietitian and executive housekeeper, King County Hospital System, Seattle. This paper was presented at the executive housekeepers' section, Association of Western Hospitals meeting, Seattle, April 1956.

Blue Blazes

Synthetic Cleaner now contains HCP!

BLUE BLAZES, the powerful synthetic cleaner, has been made *even more powerful* by the addition of HCP. The HCP ingredient activates BLUE BLAZES to provide *instantaneous penetrating action.*

How does it work? BLUE BLAZES, with HCP, immediately attacks dirt, oils, and any other foreign material that may be on the floor.

It penetrates grime, surrounds the particles, lifts them off the floor, and holds them in suspension until removed with a wet pickup vacuum, squeegee, or mop.

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Non-Ionic. Because it is completely non-ionic, BLUE BLAZES with HCP is able to pick up both positively and negatively charged dirt particles. Also, it leaves no film or other residue which would help create static charges which attract and hold dirt particles to the floor.

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noon, and I had often thought that is what I would do if I ever had to go out and get a new kind of job. I understand you can get training for it. Today, though, I met a woman who is a housekeeper, and she doesn't like it. She says it's awfully hard and you don't get much satisfaction out of it. Just a crabby boss and troublesome employes. You had better try to think of something else."

HELEN: "Maybe you are right. I had only half made up my mind, anyway."

SECOND CONVERSATION:

Scene 1: In a bus

HOUSEKEEPER: (Finding an empty seat in the bus beside a friendly looking woman) "I'm glad to find a seat. I'm a little tired tonight. It has been a busy day."

FRIENDLY WOMAN: "What business are you in?"

HOUSEKEEPER: "I'm an executive housekeeper, and usually that's a very satisfying job, but of course every job has its days."

FRIENDLY WOMAN: "Yes, every job has its problems. But you don't seem to think yours are too bad."

HOUSEKEEPER: "They are not too bad. It's a great satisfaction to keep a place clean and orderly so that people are safe and comfortable in it. My boss is considerate. I like my job."

FRIENDLY WOMAN: "Don't you have to deal with a lot of problem employes?"

HOUSEKEEPER: "There aren't many problem employes, though there are, of course, employes with problems. Most of the people who work for us are *good* employes. Of course, they are human, and they react to the way you treat them."

FRIENDLY WOMAN: "It's nice to meet someone who really likes her job. I get off at the next corner. It was nice talking to you."

Scene 2: In a living room

FRIENDLY WOMAN: (Offering a chair to a caller who has just come in) "It's nice to see you, Helen."

(Can't you imagine the rest?)

What are some of the satisfactions in being a housekeeper? False representation which is insincere will not recruit successfully. We must be honest about it. Does housekeeping have its satisfactions? Of course it does!

First, as the housekeeper on the bus said, there's the opportunity for service. This not only gives great personal satisfaction, but it can help to qualify housekeepers as a professional group. The American Medical Association has said, "The primary purpose of any profession is the service it can render." (Note that it says *any* profession.)

The American Dietetic Association opens its code of ethics with the sentence, "A professional person devotes himself to the service of humanity."

The National Executive Housekeepers Association says: "The executive housekeeper acknowledges as an obligation and a trust the responsibility for the comfort and well-being of her patrons or guests."

The housekeeper has the satisfaction of using her creative capacity and of stretching her imagination. She has the satisfaction of a respected place in the organization and, usually, of job stability. She knows a great variety of people, from the head of the organization to the least literate employe. She deals with people and furnishings and supplies, and her brain and fingers weave them together into a harmonious and gracious whole for the comfort and pleasure of her guests. It's *fun* to be a good housekeeper.

Every satisfaction always entails an obligation, however, and in the case of a professional group, part of that obligation is building for the future.

We must build both the status and the capabilities of the housekeeper. The forward-looking way to do this is by increasing the educational requirements for entrance into the housekeeping field. The time is fast approaching when college education will have become so general as to be prerequisite for any kind of supervisory or executive job. If an educational program which includes college and an internship is going to have time enough for sound growth, it is time to start now. The future is tomorrow, and tomorrow is only overnight from today.

What has this to do with recruiting? Will not the requirement of college work hinder people from coming into the housekeeping field? It might do so if we were too precipitate in setting such a requirement, if we said that from this moment nobody without a college degree and an internship could become a housekeeper. That is not the plan. The plan is that anybody who is now a housekeeper will stay as she is unless she chooses to take some of the proposed courses, and people can still come into housekeeping by the old routes. Since these old routes are not bringing in the number of people we need, it is now proposed that a new road be opened to attract an additional group not now familiar with housekeeping as a career. In effect, since the needs are not now being met, we are going to open up new country.

Do the present housekeepers need to feel uneasy at the idea of competition? Not at all. Since there are not enough qualified people now to fill the positions which are, or could be, open, employers are not encouraged to expand their requirements. If there were more good executive housekeepers, there would be more openings.

It has been suggested that salaries for housekeepers are not sufficient to attract college graduates. If that is true, there is only one remedy. Salaries never run ahead of the established status of any group. First there must be enough qualified housekeepers to set high standards and then pressure can be applied to bring salaries up. The general upgrading should improve the salaries of the whole group.

What can be done, meanwhile, by people already in the field to bring about improved status for housekeepers? A great deal can be done. This is a good time to apply gentle, but persistent, upward pressure on the status of the housekeeper.

The housekeeper must expect recognition as an executive. She must feel secure as a member of the administrative team. She must take it for granted that she is a department head among department heads. If she does not establish her own position, nobody will do it for her.

The place where she has her headquarters is important. It may not be possible for her to have a main floor office immediately, but she should make the best office arrangements she can, and she should be very particular about the appearance of whatever office she has. The polished desk is important. Her surroundings must be made to look like those of an executive even if they are in a corner of the storeroom.

The housekeeper herself must look like an executive. If she is in a hospital, she will wear a uniform, which must be well tailored, well fitted and well pressed. If she is in an organization where executives wear business clothes, she must make certain that hers are conservative and good. If one wants the status of an executive, economy should *not* begin with one's working clothes. Work is *not* the place to wear out one's old shoes. Immaculate

grooming comes next. The executive housekeeper is not a working housekeeper, and she cannot afford working hands. Her hands and her hair and her footwear must meet standards.

The housekeeper must act like an executive. It must never occur to her that she might feel inferior to anyone in the organization. Her posture and her bearing must indicate quiet self-confidence. How can we expect others to have confidence in us if we lack confidence in ourselves? The well poised, dignified person who takes it for granted that she is accepted is apt to be accepted.

The housekeeper must react like an executive. She must be ready to use her creative imagination. She must be forgetful of self and put the aims of the organization before her own aims. She must have tolerance, sympathy and understanding for all groups and their aspirations. She must have perspective, a sense of humor, and emotional stability. She must develop the impersonal approach and avoid pettiness. She must keep herself an interesting person by wise use of leisure to broaden her outlook. She must remember that the personal conduct of each member is the measure by which the individual, her colleagues, and the profession are judged.

The housekeeper must communicate like an executive. She must cultivate facility in both spoken and written language. She must be able to speak effectively to one person, several people, or a large group. She must be able to present an effective report, either verbally or in writing.

This all has to do with status, and status has to do with recruitment of the number of people we need in the quality that we want.

There is an urgent need to recruit housekeepers. There are not enough for present openings, and more openings are developing. If these positions are allowed to fall into incompetent hands, all housekeepers will suffer by association.

The quality of the job performance of housekeepers must be constantly improved to meet the advancing standards of coming times. Formal education is one of the tools that must be used to meet coming demands. This does not belittle either the present housekeepers or the splendid job that is now being done. They have learned the hard, slow way. There is no longer time for that. Timing is important just now.

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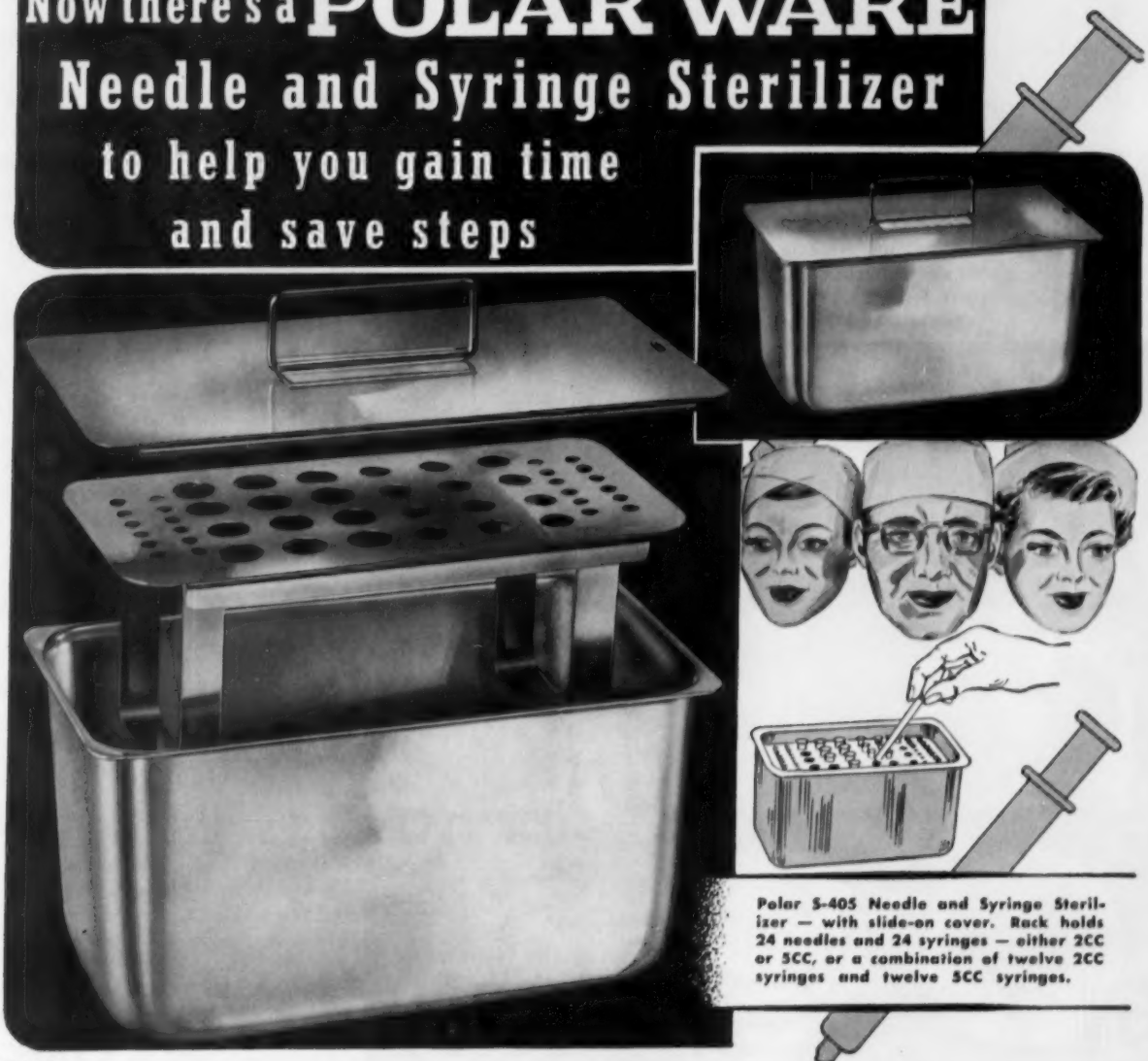

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Doors to Education Are Open

(*Continued From Page* 130)

people useful and increase their sense of importance. Answers to questions are not always forthcoming but an education should teach one to ask the right questions both about technics and about living.

One of the greatest values of an education is that it gives one so many things to worry about and struggle with and helps one see problems never seen before. Robert Frost said, "The primary reason for going to college is to find out there's a book side to everything." We all know many well educated people who had little schooling. But good schooling makes the process easier. It is like oil or grease on machinery. It overcomes resistance to new ideas, lessens friction, and teaches people how to concentrate on the thing that will solve the problems and make the whole mechanism work better.

This is an age of specialization. Everyone needs competence in a given area for self-respect, to get a job, and to feel secure in that job. The untrained and unskilled today have a precarious, uncertain future. The specialist not only must do one thing well, but also must realize its importance in the general setup. He must feel that he is one of a team highly essential even though he is only an outfielder. He must also feel that his team is doing a worth-while piece of work. This he needs for his own mental health.

When we feel that we are even a minor part of something vital, we develop a healthy conceit. Schooling helps build this healthy conceit and also helps people acquire a feeling of self-fulfillment.

Education shows how significant and important a job is. Some mothers, for example, feel that they are wasting their time and abilities when they are just homemakers. The trained home economist who is also a mother knows she is the cornerstone of society and she knows that rearing children intelligently and keeping her husband happy and fit are a woman's most important tasks.

The hospital housekeeper who studies will never feel inferior to anyone, for she will realize that her work is essential to the well-being of patient and staff. She is aware that safety of floors, absolute cleanliness of rooms, wise purchase and use of materials, and happiness of her personnel are the cornerstone of hospital work.

Here are four areas in which college study should help the housekeeper's job to be easier. First, a course in textiles should show her what would meet her specific needs and enable her to ask the right questions before she buys sheets, blankets, towels or curtains.

Let us consider sheets, for example: What specifications shall she set down?

Quality and type of fiber.

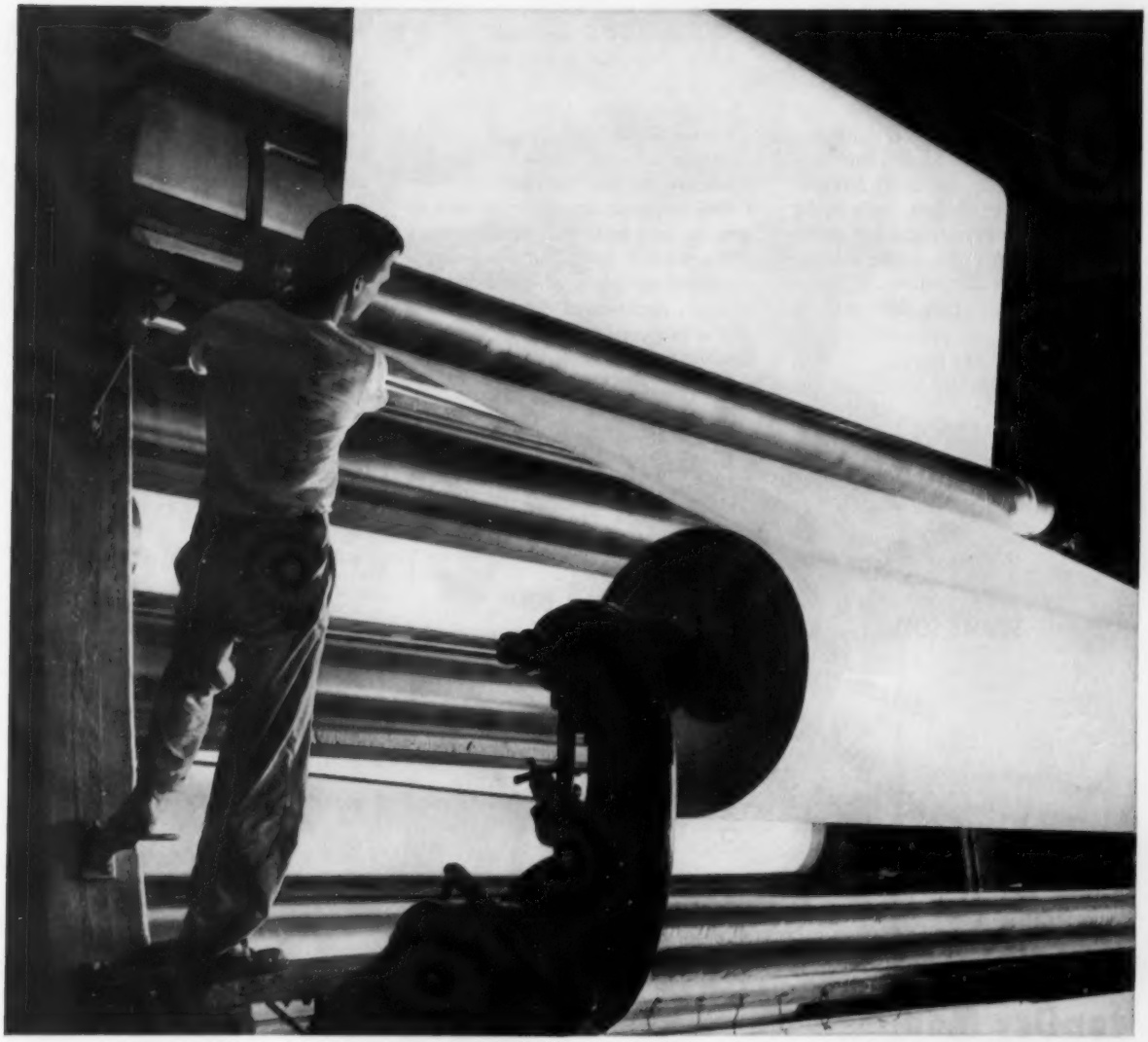
Thread count—percale or muslin.

Guarantee regarding shrinkage.

Size—flat or contour.

She will have to know the effect of laundry methods on finer and heavier sheets. If contour sheets seem desirable, how could they be folded for storage? What of their durability?

If she orders diapers, does she need 27 inches square, 20 by 40 inch, or would 20 inches meet the needs in the nursery where 95 per cent of babies are under a week old? How durable is birdseye compared with gauze or flan-



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nel? Do any of these tend to get gray when no bleach is used? Do bleaches or detergents affect a baby's skin? Would cleaning tissue inside diapers cut laundry costs and be acceptable?

In home management she would become more alert to work simplification methods. Are too many motions being made, are efficient tools being used, are the layouts right for maximum results? Are the workers happy or frustrated at the efforts to make them efficient? Are they tired to death of analysis?

Do you know this poem?

"The centipede was happy quite
until the toad in fun said,
which foot comes after which
when you begin to run
and brought his mind
to such a pitch
he lay exhausted in the ditch
considering how to run."

Overemphasis on efficiency leads to tension, hurt feelings, and inefficiency in the worker. Supervising housekeepers therefore might benefit from psychology, methods of teaching, and a course in personnel management or a combination of these. From these one learns that it is far better to demonstrate first the correct methods than to wait and criticize the worker's methods. She learns that an experimental attitude in the supervisor gets further and shows she is anxious to study the situation with the worker rather than hand out directions and criticisms. She learns not only the value of teamwork with the group but how to achieve teamwork. In these courses she comes to understand what makes workers happy and what leads to frustration. She knows that each wants to be treated as an individual with a personality, not as just another employe.

Workers look up to supervisors who know more than they do and, for this reason, sufficient knowledge of physics and microbiology to speak with authority about the use of equipment or sanitation technics is all to the good.

I would suggest a course in record keeping, filing and accounts for all executive housekeepers so that they feel responsibility for leaving adequate records for those who succeed them and know also how to use the records others have left for them.

It is doubtful that merely by taking a university course many college girls could be prepared for housekeeping, and it is unlikely they would choose such a career. But the mature woman who has managed a home well and whose family no longer needs her full time would be a desirable recruit, particularly if she were a college graduate or had some college training.

After she has taken the courses listed by the National Executive Housekeepers Association as essential, she should become a trainee and be guided and supervised by some of the present excellent housekeepers. More mature women are working now than ever before. Their average age is over 38 years. More than 10,000,000—more than half—of these women are married. All that is needed now is to bring the right women back to school and guide them to the right positions.

Nothing gives more prestige to an association than educational requirements for membership. In the future I should like housekeepers to have status equal to that of other hospital groups and hope, therefore, that they will give consideration to specialized training. Not one in a hundred who studies regrets the time spent, nor merely because he becomes a more efficient worker, but because all study intensifies interest in life itself.

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Nurse Education Costs

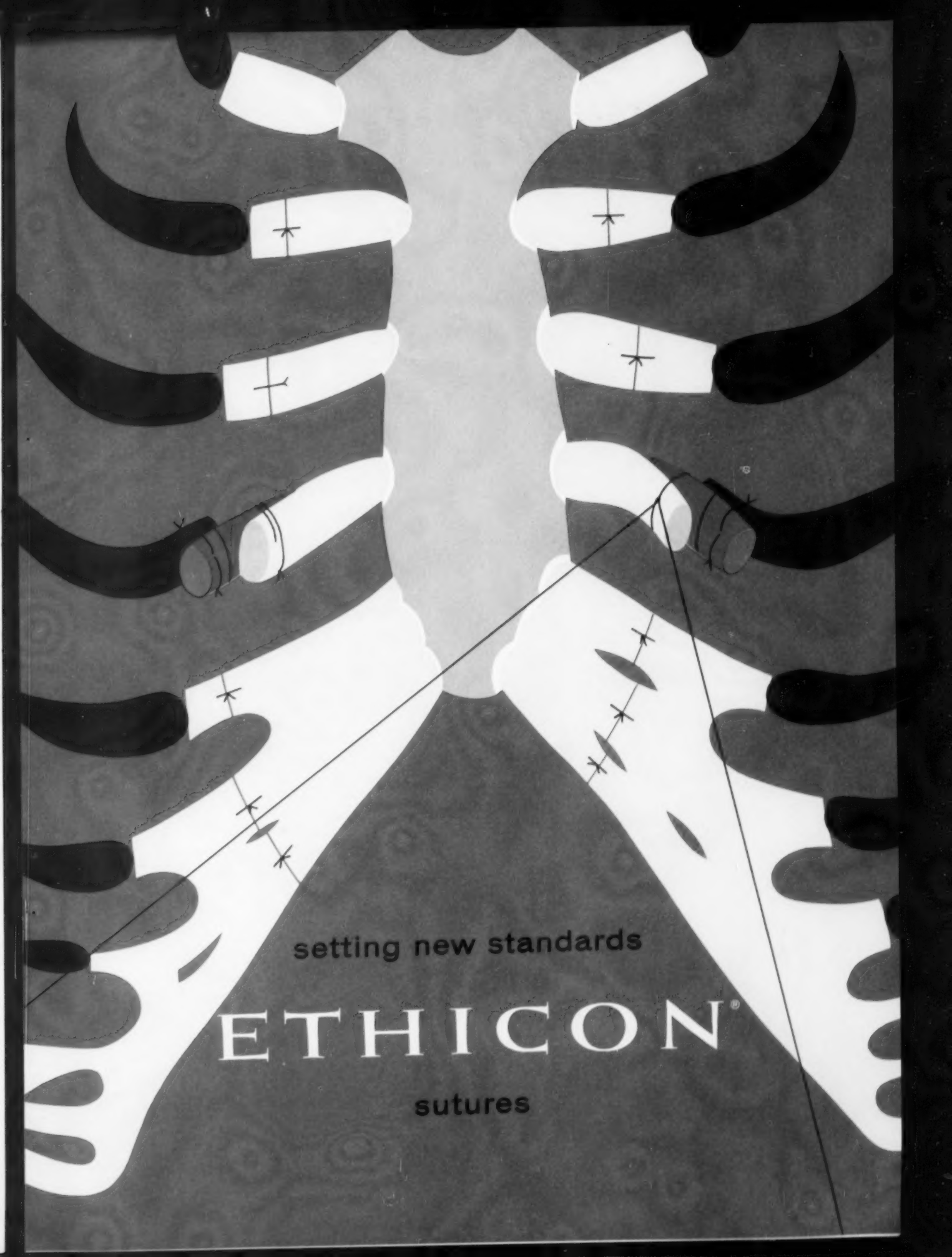
(*Continued From Page* 71)

Hospital and nursing administrators have thought, rather naturally, that the value of student service increased progressively as the student advances in the school. As a result of this thinking, arbitrarily increasing values have been placed upon the hours of first, second and third year students, but as has been pointed out, there are many variable factors that influence effectiveness of the student hour. The results of this analysis compare favorably with situations found during the original work by Pfefferkorn and Rovetta. The average effectiveness factor found in this hospital is 86 per cent, higher than the median 76.5 per cent found in their study of 12 representative hospitals. We were particularly interested in determining the effectiveness of student hours according to class groups, and found that this also compares favorably with the median hospital in their study:

Class Group	I.M.H.	Median Hospital
Third-year students	99%	84.0%
Second-year students	83%	80.0%
First-year students	59%	67.0%
All students	86%	76.5%

The evidence points to one acid test of the effectiveness of students expressed in financial terms. If the student were not there, how would the hospital operate the service, and what would the substituted method of operation cost? As seen from the figures, the value of nursing service rendered by the student nurses amounted to $217,949.80, in itself a staggering amount. The situation that now exists in a majority of nursing services is a real shortage of graduate nurses. To replace the student nurse service hours, at the time of this study, would have required 84 graduate nurses. This situation appears, at the present time, to be inescapable, and results in day shifts being staffed by a majority of graduate nurses and evening and night shifts being staffed by a majority of the student nurse group.

However, in any discussion or study that is made to determine the cost of operating a school of nursing, serious consideration should be given to two very real questions: What is the additional cost involved because we are operating a school of nursing? Second, on a "man to man" basis, how and with whom will we replace the student nurse hours of service to the hospital?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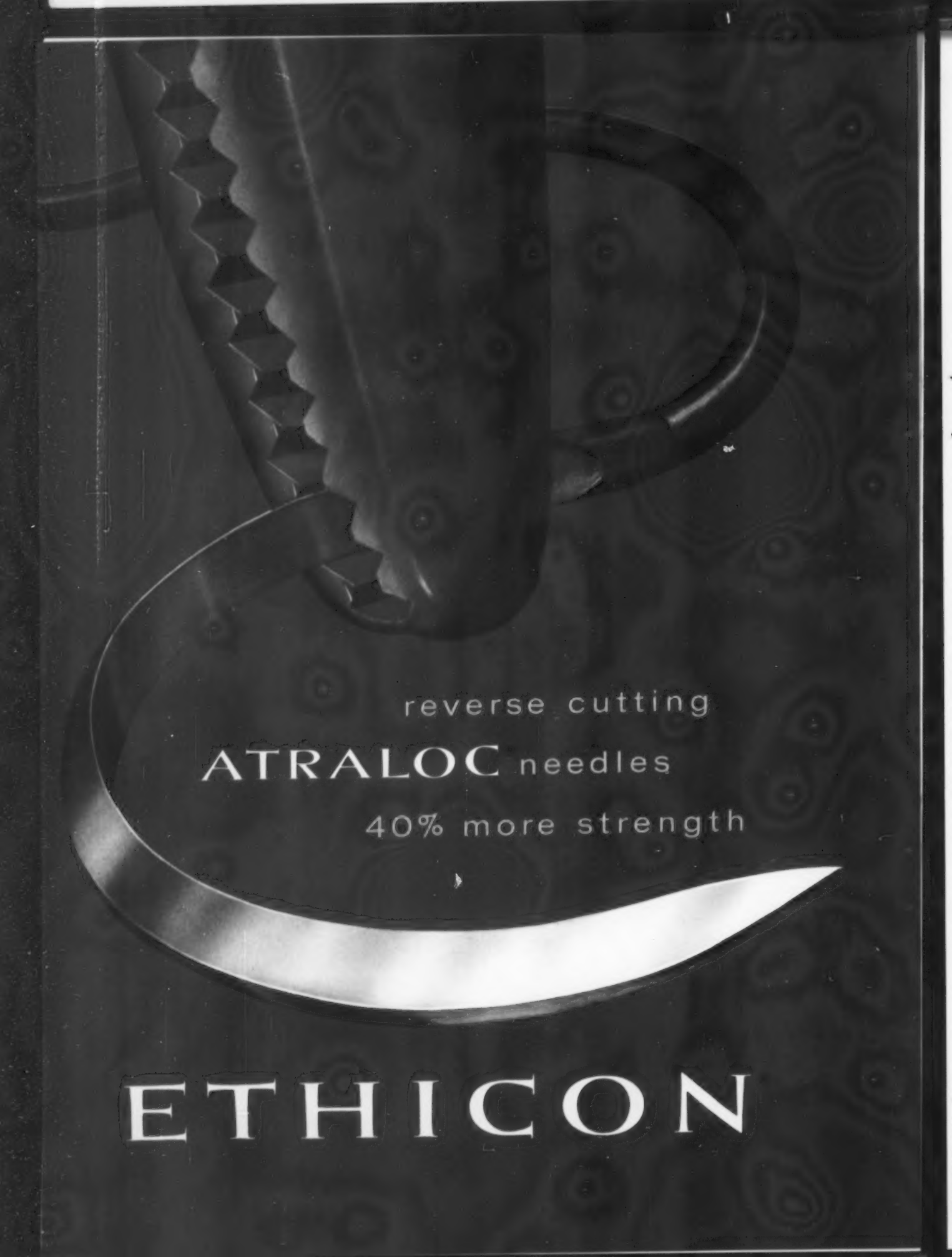
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Survey Offers Short Cuts to Savings

(*Continued From Page 74*)

served as a charge slip also, was presented. This relieved the department personnel of doing clerical work and gave the registration clerk, who served also as cashier, a fine system by which to check payments. Department employes were responsible only for entering the charge and instructing the patient where to pay. Irregular requests for work to be done or irregular requests for credit were picked up early so that we had time for investigation while the patient was still in the department.

BUSINESS PROCEDURES

Since our bookkeeping department had shifted a few months earlier to a new Indiana State Board of Accounts (to which organization we are responsible as we are county owned and operated) system of bookkeeping, we found many displacements in this area to be corrected. We welcomed the help of the business specialist-engineer in assisting us here. The basis of this system was earned income in contrast with our earlier one of cash receipts.

The need for revision of our multiple form for admission information was met by a new 11 part form that included:

1. A permanent financial record.
2. One copy of financial record for patient.
3. One copy of financial record for insurance company.
4. A 3 by 5 inch card for medical records permanent file.
5. The front sheet of patient's medical record.
6. A copy of admitting information for insurance clerk and office supervisor.
7. A copy of admitting information for 70 mm. chest x-ray requisition.
8. A copy of admitting information for routine laboratory tests requisition.
9. A copy of admitting information for dismissal notice with space for ward clerk to note likely late charges.
10. A copy of admitting information for the physician. This is placed in the physician's hospital mail box at 7 a.m., which relieves his office staff of calling our records and insurance clerks for information.
11. A copy of admitting information for receptionists who readdress mail and direct visitors.

Our whole idea was to get all the information that we could in the one form to save duplication of effort. An electric typewriter was obtained to make it possible to type the multiform.

Reviewing the total picture of the paper work relating to identification, we learned we did not have the many medical chart sheets filled out or the many other items of information that require identification as the patient's stay progresses. To take care of this we obtained a special stencil. The admitting typist prepares the stencil at the same time as the multiple form and sends the stencil to the nursing unit with the patient's record top sheet. This stencil has patient's name, hospital number, and name of physician. We considered other methods, such as the metal plates, but we found the stencil provides a more flexible usage, costs much less, can be made up by anyone, and does our job very adequately.

An accounting machine was installed to do many jobs heretofore done by hand. Although the investment was large, the machine's usefulness is being broadened monthly as the staff is able to master new procedures on it and as we obtain permission from the state board of accounts to use special forms. (This body is highly interested in efficient, economical operation and has sanctioned the use of all forms requested.) We use it for all posting of daily charges, making up daily accrual sheets and monthly accruals, and recording of accounts receivable and accounts payable. A bi-monthly payroll is being written on the machine. If we had not had a gift to cover the cost of this machine, I would have suggested a monthly pay plan as its does pay for itself in labor saved.

We renegotiated with the heads of special service departments for contracts based on percentage of earned income (total billings or earnings which includes unpaid bills as well as collected receipts) instead of cash receipts.

Minor changes in office arrangement of furnishings and equipment made it possible to combine jobs and provide meal-time relief, allowing longer hours coverage and less friction over relief periods.

Many of the notebooks of information were discarded in favor of desk calendars throughout the department and the supervisor was asked, as were all others in the house, to set up no new paper systems without consulting the administrator first. This has tended to discourage superficial, time consuming ways of getting basic situations corrected.

NURSING

More time was spent by the engineer in nursing than in any other department, as there were more employes there and more frustration attached to the current "shortage" concept. The conditions that relate to the nurse as a worker and as a member of a team were dealt with in another article in this magazine* so we shall confine our remarks here to the recommendations not covered in that issue. The first problem found in nursing appeared to be that the chief nurse's job had become purely administrative and that other duties should be removed from it; hence, the person who was required to do the job should be selected on the basis of her administrative ability. Furthermore, there was the problem of unification of practice, and need for standardization of layout. In a graduate staff with representatives of several schools of various periods, it seemed expedient to make a continuous effort to standardize all procedures in their simplest forms.

A need to standardize the physical plant was obvious to the engineer. This was especially true of the medicine rooms located behind the nurses' desks. Nurses stated that, when assigned to relief or to duty on a different floor, the greatest problem at first was to learn where to locate the items with which they worked.

The six head nurses together agreed upon a set of rules. Then they went about labeling, identifying and indexing the items and the space. This operation was extended to accessory rooms such as linen, small equipment, large equipment, janitor and housekeeping cupboards, and clean and

*Murphy, Olive M. and Pansky, Emil J.: Make the Most of Employes' Opinions. Mod. Hosp. 83:67 (November) 1955.

soiled utility areas on every unit. We are sure the nurses were amazed at what they were able to accomplish and they realized that they had a continuing job on their hands. There is an alphabetical index of the contents of each room at the station desk. As new nurses come in or as others move from unit to unit to relieve, they readily adjust themselves to the things they need by becoming familiar with the index of product and space which are uniform in all areas.

Better communication was needed. Great importance was laid upon the dissemination of information to all nursing personnel through bulletin boards and bulletins. A monthly newsletter was started as a carry-over of information presented at the inservice education programs to keep necessary absentees informed.

Minor structural changes were made on the units to give the nursing personnel better control of visitors.

One recommendation called for a program to train the registered nurse away from the concept that she is an individual worker into the realization that she is the *leader* of a group of workers. We gave it every consideration. A "Ten Commandments of Nursing" sheet was placed into the hands of each staff nurse and posted at each station by the administrator at the time the engineer reported his findings to the nursing staff. It frequently is referred to at nurses' staff meeting for reports of progress.

This list was as follows:

1. Every R.N. must learn that she is, herself, a supervisor of the other people working on her unit.

2. She must get in the habit of looking more closely at the work done by all these people on her unit.

3. She must get in the habit of commending these workers more when they do a good job; and contrariwise, if they have not done a good job, she must instruct them *how* to do a good job. After instructions she must check, check, check to see if they follow through.

4. The worker should realize that there is someone looking at his work and that he may expect *commendation* or *instruction*. If after instruction an inferior job is still being done, the nursing office should be notified.

5. The R.N. should be thinking of some sort of checkoff "evaluation of employes" sheet to be kept by the head nurse.

6. She must evolve a system of having all procedures looked at periodically regardless of who performs them to see if they are necessary and being done in the most efficient, timesaving manner.

7. Nurses should become aware of the time they spend doing different aspects of their job. To this end keeping a time chart for a week or two at intervals would help her to see whether or not there are things she should delegate to another worker and thus gain time for bedside care.

8. For this purpose she needs to look at these duties and possibly at times redefine the responsibilities of nurse's aides, clerks and R.N.'s with guidance by the head of the nursing service.

9. We will give better care to the patient if we include the auxiliary nurse in our report *at all shift changes*. She can be taught, if properly indoctrinated and cautiously checked by her head nurse, that this information is confidential and must be kept confidential.

10. Every nurse should identify herself to the patient on her first call. Because of rotation and night calls

Bassick Casters Reduce Surgical Explosion Hazards

That's why Wilmot Castle Company, Rochester, New York, a leading manufacturer of surgical lights, insists on Bassick casters.

For these casters have electrically conductive wheels which ground static electricity before it can build up to spark highly explosive operating room gases. And the mobile maneuverability they contribute, too, is one of the featured advantages of Castle lights.

It's a good idea, in fact, to look for Bassick casters on all mobile hospital equipment you buy. They're one good indication of the high quality of the equipment. They roll smoothly, swivel easily and won't mar floors or raise a racket. Easy to maintain, they stand up to punishment, too. Why not get Bassick Diamond Arrow Casters for all your hospital beds, tables and other mobile equipment? THE BASSICK COMPANY, Bridgeport 2, Conn. *In Canada:* Belleville, Ont. 6.67

WHEEL BRAKES are available on all sizes of these Bassick casters, 2" and up. They're important on beds, X-ray machines and any hospital equipment to stop the normal easy action when movement is not desired.

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A DIVISION OF STEWART WARNER

MAKING MORE KINDS OF CASTERS . . . MAKING CASTERS DO MORE

Open the Door!

TO EASIER FLOOR CLEANING

with WHITE

MOPPING EQUIPMENT

And lower cleaning costs, too! When you use WHITE Floor Cleaning Tools you can be sure of years of service from your mopping equipment because WHITE builds only quality into every one of the 252 cleaning tools sold under one brand name.

SEND FOR CATALOG NO. 156

At left: The Mopmaster Double Outfit made in four sizes.

Below: The Tym-saver Single Outfit made in four sizes.

WHITE MOP WRINGER COMPANY

9 MOHAWK STREET • FULTONVILLE, NEW YORK

CANADIAN FACTORY: PARIS, ONTARIO, CANADA

The ONE complete line of floor cleaning tools

on patients we suggest that nurses wear name tags.

Three one-half hour lectures to the staff by an industrial engineer on "Elements of Supervision" were arranged, and all nurses were asked to attend. Incentive pay increases have been offered nurses who go to our near-by university for courses in supervision and our nurses are going and making plans to continue to go.

ADMINISTRATOR

In order to make certain we were following procedures determined by our study, it was necessary to devise a simple system of checking. Consequently, a report form was worked out for each department relating the amount of labor by days with a measure of the work load. These reports are compiled monthly and if they indicate any recession the department head is asked to explain.

Many good things besides savings came about as a result of our having an engineer to help us. We learned where traits of character and traits of management lay and sometimes we were pleasantly surprised to find them. It was a fine opportunity to learn how earnest were the efforts at every level. Morale of the whole staff was elevated. All came to realize that effective operation resulted when close working relationships existed. We have all developed a habit of looking and wondering if there is a better way.

Management and staff are impressed with the spectacular aspects of our first results, but we are eager to learn the continuing favorable conditions that will result from further application of the principles learned and that in the long run will pay off generously.

It may seem to the average administrator of a small hospital that his plant and staff are too small to need or afford such a study. But we offer the challenge that if he will attempt such a study he will have many surprises and, probably, he will not have to pay too high a price for them. If his problem is finding someone like our engineer adviser, we suggest that most communities could produce such a man—perhaps from industry. If not, a larger neighboring community might send someone, or the Society for the Advancement of Management will be glad to find the proper person if the hospital administrator will only let his needs be known.

Veterans' Administration Hospital, Minneapolis, Minn.
Acoustical Contractor: The Kerntile Company
Acoustical Material: Armstrong Travertone

This noise-quieting ceiling adds distinctive beauty

The lobby area of the Veterans' Administration Hospital in Minneapolis effectively expresses the building's character. It combines the restful quiet of a medical center with the dignified beauty associated with government buildings. Both qualities are provided in the sound-absorbing ceilings of Armstrong Travertone.

A highly efficient acoustical material, Travertone soaks up as much as 80% of the noise that strikes its surface, providing the quiet so desirable in a hospital. Its handsomely fissured surface, resembling travertine marble, blends equally well with the stately terrazzo and marble floors and walls and the modern shapes of the chairs and couches.

Completely fire-safe . . . Travertone's mineral wool fiber composition adds extra fire-safety to any area. Rated incombustible, it meets even the strictest local building codes.

Economical to maintain . . . You can keep Travertone new looking for years with no more maintenance than you'd need for an ordinary ceiling. Travertone's white paint finish can be cleaned or repainted when necessary without impairing acoustical efficiency. In addition, Travertone forms a permanent ceiling . . . one that will not crack.

Light reflective . . . Travertone's smooth white finish has high light reflectivity, providing evenly diffused, glare-free illumination. Full details about Travertone and the entire line of Armstrong sound-conditioning materials are available from your Armstrong Acoustical Contractor.

Free booklet, "Quiet at Work," shows how sound conditioning can work for you by increasing comfort and efficiency. For your copy, write Armstrong Cork Company, 4208 Union St., Lancaster, Pennsylvania.

Armstrong

ACOUSTICAL MATERIALS

Cushiontone® • Travertone* • Crestone* • Minatone®
Arrestone® • Corkoustic® • Perforated Asbestos Board

*TRADE-MARK

A Guide to Budget Management

(*Continued From Page 79*)

3. Inpatient special service income breakdown. (See Exhibit 23.)

4. Outpatient special service income. (See Exhibit 24.)

5. Free services and allowances. Reported on Exhibit 21 and itemized by classification.

6. Nonoperating income. Reported on Exhibit 21 and itemized by classification.

7. Expenses and summary of operating expenses. Reported on Exhibit 21 and itemized by classification.

8. Expense reports for each department. (See Step 2 and Exhibit 25.)

STEP 2

That the value of the budget depends largely on the active part played by department heads is worthy of repetition. Knowledge of results is a basic concept of the philosophy of learning and, therefore, is logically a second phase of department head participation. Each month there should be a report to the departments of the budgeted expenses compared with the department's actual expenses. Any major deviation from the budgeted figures should be discussed with prop-

Exhibit 21—XYZ HOSPITAL

Monthly and Cumulative Summary of Income and Expenses

	Current month					
	Month Actual	Month Budget	Over (CR) or Under Budget	Year to Date Actual	Year to Date Budget	Over (CR) or Under Budget
INCOME						
Gross earnings						
Less free service and allowance						
Net income						
Nonoperating income						
Total income						
Expenses						
Operating expenses						
Nonoperating expenses						
Amortization and depreciation						
Total expenses						
Net increase of loss						
Summary of operating expenses						
Salaries						
Supplies						
Food						
Miscellaneous						
Repair and maintenance						
Social security and annuity						
Statistics						
Admissions						
Adults						
Newborn						
Patient days						
Medical and surgical						
OB						
Total						
Occupancy per cent						
Medical and surgical						
OB						
Total						

When this report is filled in it contains (1) the actual figure (both month and year to date) for each of the categories listed at left; (2) the figure that was budgeted, and (3) the difference—either over or under—between the amount budgeted and that spent.

Exhibit 22—XYZ HOSPITAL—Total Income

	INCOME FOR THE MONTH OF _____ AND YEAR TO DATE _____ MONTHS					
	Month Actual	Month Budget	Over (CR) or Under Budget	Year to Date Actual	Year to Date Budget	Over (CR) or Under Budget
Total room and board						
Total special services						
Total miscellaneous						
Total income						
Total inpatient income						
Total outpatient income						
Total income						

WEAR·EVER *presents* 56's Greatest Utensil Sale

PAN·O·RAMA

Standard Weight Specials

Heavy Duty Specials

Introducing

THE PAN·O·RAMA SPECTACULAR

A revolutionary **NEW** better baking surface

Roast & Bake Pan Specials

Aug. 1 to Sept. 30 *Special Prices* on these top quality Aluminum Utensils

STANDARD WEIGHT SPECIALS

Cat. No.	Description	Sale Price
4302	2½ Gal. Stock Pot	$ 7.45
4189	Cover to fit	2.50
4304	4 Gal. Stock Pot	11.50
4190	Cover to fit	2.95
4306	6 Gal. Stock Pot	14.79
4192	Cover to fit	3.75
4307½	7½ Gal. Stock Pot	17.85
4193	Cover to fit	3.95
4310	10 Gal. Stock Pot	10.95
4194	Cover to fit	4.25
4341½	1½ Qt. Sauce Pan	2.00
4341½C	Cover to fit	1.10
4342½	2½ Qt. Sauce Pan	3.50
4342½C	Cover to fit	1.40
4343½	3½ Qt. Sauce Pan	4.10
4343½C	Cover to fit	1.50
4344½	4½ Qt. Sauce Pan	4.75
4344½C	Cover to fit	1.85
4345½	5½ Qt. Sauce Pan	4.85
4345½C	Cover to fit	1.95
4347	7 Qt. Sauce Pan	6.35
4347C	Cover to fit	2.10
4348½	8½ Qt. Sauce Pan	6.60
4348½C	Cover to fit	2.20
4350	10 Qt. Sauce Pan	7.95
4350C	Cover to fit	2.85
4611	11 Qt. Colander	8.80
4616	16 Qt. Colander	11.70

HEAVY DUTY SPECIALS

Cat. No.	Description	Sale Price
4251	20 Qt. Stock Pot	$26.95
4191	Cover to fit	3.50
4254	40 Qt. Stock Pot	41.50
4194	Cover to fit	4.25
4151	12 Qt. Sauce Pot	21.00
4191	Cover to fit	3.50
4152	14 Qt. Sauce Pot	23.50
4192	Cover to fit	3.75
4153	20 Qt. Sauce Pot	3.95
4193	Cover to fit	34.50
4154	26 Qt. Sauce Pot	4.25
4154	Cover to fit	

ROAST & BAKE PAN SPECIALS

Cat. No.	Description	Sale Price
4422	"Twin Oven" Bake Pan, 2¼" deep	$ 5.95
4423	"Twin Oven" Roast Pan, 3½" deep	6.95
4426	"Twin Oven" Roast Pan, 6½" deep	12.35
4426R	Rack for 4426	7.50
4424	Cover for 4422, 4423	3.95
4431	"Full Oven" Bake Sheet, 1½" deep	6.25
4432	"Full Oven" Roast Pan, 2½" deep	9.65
4433	"Full Oven" Roast Pan, 3½" deep	10.35
4436	"Full Oven" Roast Pan, 6½" deep	16.95
4436R	Rack for 4436	10.95
4430	Cover for 4432, 4433	6.35
4483	Std. Roast Pan, 18" x 22" x 4½"	16.95
4483½	Logged Pan for closed roasting	22.95
5300-T	Textur-ite Bake Sheet, 17-3/16" x 25-3/16" x 1"	5.80
A-5300-T	(Same with Alumilite Finish)	6.60

(All prices slightly higher in the West)

AT YOUR WEAR·EVER DEALER'S NOW...VISIT OR CALL HIM AND SAVE $$

The Aluminum Cooking Utensil Co., Inc., Wear·Ever Building, New Kensington, Pa.

Exhibit 23—XYZ HOSPITAL—Inpatient Income

INCOME FOR THE MONTH OF_____
AND YEAR TO DATE_____MONTHS

	Month Actual	Month Budget	Over (CR) or Under Budget	Year to Date Actual	Year to Date Budget	Over (CR) or Under Budget
Special Services						
Operating room						
Anesthesia						
X-ray						
E.K.G.						
Metabolism						
Physical therapy						
Pharmacy						
Oxygen						
Laboratory						
Telephone						
Guest meals						
Guest rooms						
Etc.						
Total Special Services						

Inpatient special service income form.

Exhibit 24—XYZ HOSPITAL—Outpatient Income

INCOME FOR THE MONTH OF_____
AND YEAR TO DATE_____MONTHS

	Month Actual	Month Budget	Over (CR) or Under Budget	Year to Date Actual	Year to Date Budget	Over (CR) or Under Budget
Special services						
Operating room						
Anesthesia						
X-ray						
E.K.G.						
Metabolism						
Physical therapy						
Pharmacy						
Emergency room						
Telephone						
Laboratory						
Etc.						
Total						

Outpatient special service income form.

Exhibit 25—XYZ HOSPITAL

Month_____

	Month Actual	Month Budget	Over (CR) or Under Budget	Year-to Date Actual	Year-to Date Budget	Over (CR) or Under Budget
Delivery room						
Salary and wages						
Total salary and wages						
Supplies						
Gauze						
Drugs						
Instruments						
Solutions						
Sundry						
Total supplies						
Miscellaneous						
Repair and maintenance						
Social security						
Annuity						
Total						

Expense reporting form used for the delivery room.

erly authorized administrative personnel in order that immediate corrective action can be taken if necessary.

Exhibit 25 shows the expense reporting form used for the delivery room.

There is no easy solution to hospitals' economic problems; however, the use of a management budget will, in time, have a beneficial effect on operations by eliminating inefficient and uneconomical practices.

Department head participation, essential statistics, administrative controls and knowledge of results are all highly essential tools in the preparation and functioning of a management budget.

Policy and Methods for Collecting Bills

(*Continued From Page* 87)

have as high as 35 per cent in this group.

Ninety-four per cent of the hospitals have a regular routine collection procedure. This is handled by the credit department or credit manager in 54 per cent of the hospitals. Twelve per cent have a special collection department for this purpose. The accounting department handles the collection routine in 20 per cent of the reporting hospitals.

Some of the other departments that handle collections are: business office, cashier, patient relations unit. In 4 per cent, no one specific person is responsible for collections.

The age of an account when it is referred to the collection department of the hospital varies considerably among hospitals:

Immediate	30%
15 days or less	9%
30 days	22%
60 days	9%
3-6 months	16%
7-12 months	7%
Indefinite	7%

Eighty-nine per cent of the hospitals refer overdue accounts to an outside collection agency. This is done most frequently when the account is 90 days overdue. However, a large number (17 per cent) have no specified time for referring them, but give each account individual consideration.

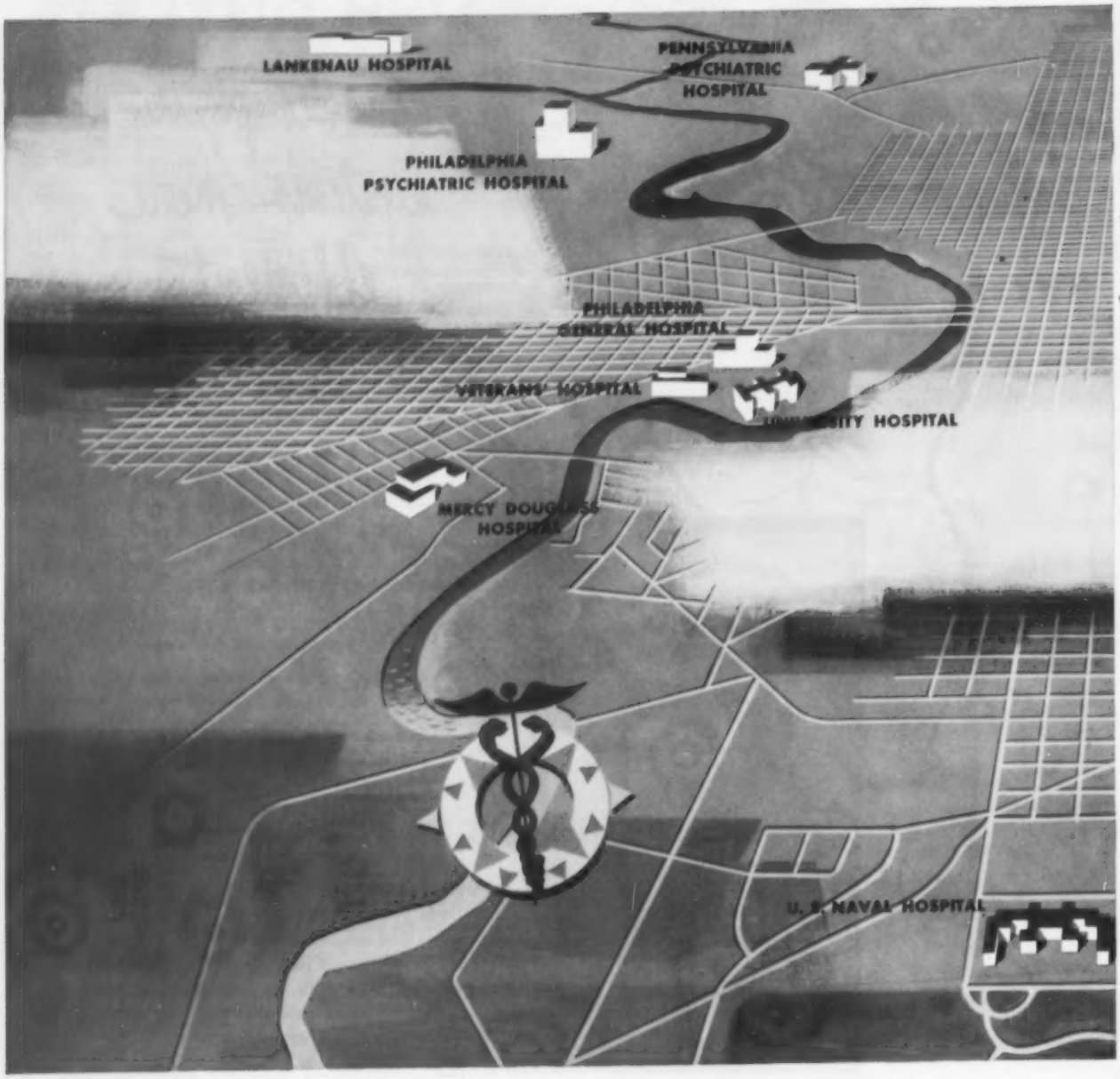
All of the reporting hospitals make some attempt to collect overdue bills before referring them to an outside agency.

Minimum accounts referred to an outside collection agent vary from $2 to $20; $10 is the most frequently mentioned minimum amount.

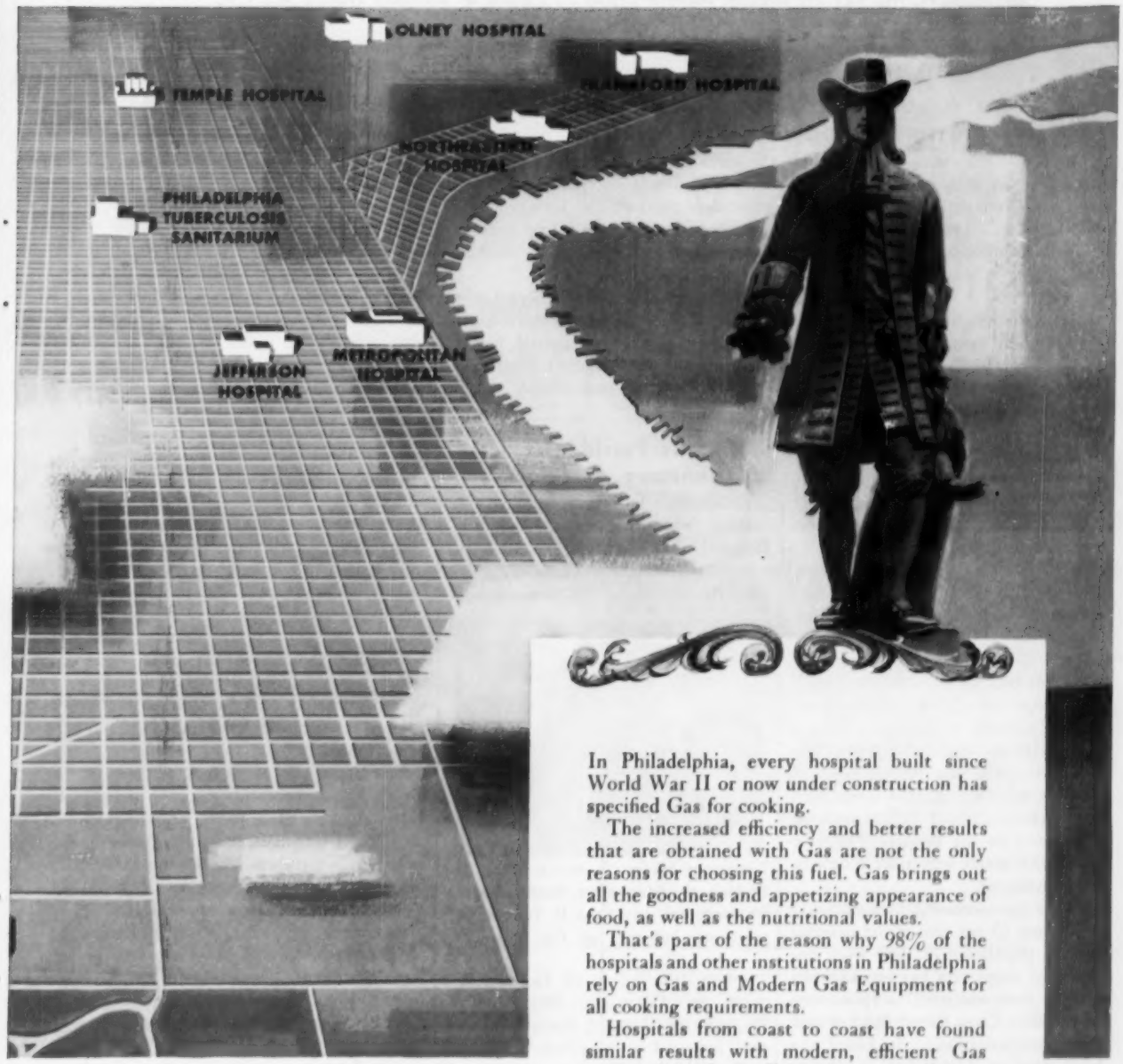
COLLECTION FEES VARY

Collection agency fees vary for the same hospital depending upon the difficulty of collection. A more or less standard fee appears to be 33⅓ per cent of the account collected. When legal action or out-of-state action is necessary, a higher fee is charged. One or two hospitals mentioned that their collection agencies charged a flat dollar amount for each account. In other hospitals, collections are handled by the hospital attorney and he receives no fee other than his annual retainer.

IN PHILADELPHIA, ALL THE NEW



HOSPITALS COOK WITH *GAS*



In Philadelphia, every hospital built since World War II or now under construction has specified Gas for cooking.

The increased efficiency and better results that are obtained with Gas are not the only reasons for choosing this fuel. Gas brings out all the goodness and appetizing appearance of food, as well as the nutritional values.

That's part of the reason why 98% of the hospitals and other institutions in Philadelphia rely on Gas and Modern Gas Equipment for all cooking requirements.

Hospitals from coast to coast have found similar results with modern, efficient Gas equipped kitchens. For information on any institutional feeding problem, call your Gas Company Commercial Specialist and discuss the economies and results Modern Gas Equipment can provide. *American Gas Association.*

NEWS DIGEST

Blue Cross Association to Write National Contracts . . . Detroit Study Shows Hospitals Divided on Integration . . . Tennessee Elects Edgar H. Stohler . . . William H. Markey Jr. Dies in Airline Crash . . . Dale G. Deckert Heads A.S.T.A.

Blue Cross Association Reorganized to Write National Contracts for Plans

CHICAGO.—The Blue Cross Association has been reorganized by the Blue Cross Commission and will operate, with a full-time, paid staff, as a national enrollment force for Blue Cross plans, it was announced here last month.

Reorganization was effected by the commission following study and recommendations made by a committee of 12 representing the largest Blue Cross plans in the country, it was reported.

Location of the association's headquarters has not been determined but the association office may be located in Washington, D.C., a commission staff member said.

The Blue Cross Association was first established as a not-for-profit corporation in 1948 to create a framework for Health Service, Inc., a stock insurance company performing an underwriting service for Blue Cross, it was explained.

The new association will be managed by a board of governors elected by participating plans, the commission said. Plans will vote on the basis of one vote for every 25,000 active subscriber contracts, and capital will be contributed on the basis of $100 for each 25,000 active subscriber contracts, it was indicated.

"With the increasing diversification of industry, 65 per cent of the national working population in 1955 were employed by employers having employes in more than one state," a spokesman for the Blue Cross Commission stated. "Thus reorganization of the Blue Cross Association as a national enrollment force will provide an important new service for large groups of employes."

The first board of governors of the new association will be elected by a mail vote to be conducted this month, it was explained. Every approved Blue Cross plan is eligible for membership.

The national Blue Cross Association will write service contract benefits, and participating plans will provide the service locally, it was reported. If a local plan will not participate in a particular contract, it is stipulated, another plan may come in and provide benefits in the area ordinarily covered by the nonparticipating plan.

The relationship of the Blue Cross Commission to the American Hospital Association remains unchanged, it was explained. The association is entirely separate from the commission.

Stohler Is President-Elect of Tennessee Association

MEMPHIS, TENN. — Edgar H. Stohler, administrator of Memorial Hospital, Johnson City, was named president-elect of the Tennessee Hospital Association at the annual meeting here June 14 to 16. He succeeds John H. Tallmadge, Fort Sanders Presbyterian Hospital, Knoxville, who was inducted as president.

Tennessee officers (l. to r.): Edgar H. Stohler, president-elect; Frank Magoffin, treasurer, and John H. Tallmadge, who was inducted as the president.

Dr. Frank S. Bradley, director of Barnes Hospital, St. Louis, told the association meeting, "How much socialized medicine is the question facing the American public today, not 'if we can' or 'if we should.' Socialized medicine, in its proper place, is necessary to society when a lack of financial resources, facilities or military stability exists."

(*Continued on Insert Op.* 177)

Dale G. Deckert Succeeds Herbert L. Crowley Jr. as President of A.S.T.A.

H. L. Crowley Jr.

CHICAGO. — Herbert L. Crowley Jr. of the Crowley and Gardner Company, Boston, was inducted into the office of president of the American Surgical Trade Association at its 54th annual convention held here June 26 to 29. Representatives from 91 surgical and hospital supply distributors all over the country and 64 manufacturers attended the meeting. Featured speakers included Dr. Kenneth McFarland, educational consultant to General Motors Company, and Robert Perry of the Chicago area office of the United States Department of Commerce.

Mr. Perry discussed the value of training and counseling programs for all salesmen and dealer employes. He pointed out that such a program would put salesmen in a better position to service hospitals and hence increase the surgical dealers' business.

In addition to a panel discussion on "Improving Manufacturer-Dealer Relations," members of the association conducted management seminars on such subjects as personnel management problems, business forums, advertising, organizing the service department, compensation plans, cost and accounting procedures, inventory and stock control, and financing sales.

In addition to Mr. Crowley, the following officers were elected: president-elect, Dale G. Deckert Sr., Deckert Surgical Company, Santa Anna, Calif.; treasurer, C. Richard Lovelace, Murray-Baumgartner Surgical Instrument Company, Baltimore; vice president, Harold L. Larson, Kreiser's, Inc., Sioux Falls, S.D.; second vice president, Thornton K. Shaw, Shaw Surgical Supply Company, Inc., Seattle.

Quaker Oats

...an all 'round Ingredient, too

Yeast and Quick Breads

Rolls, coffee cakes, muffins, quick breads—all with a rich nutty flavor. Stay extra fresh and moist.

Cookies

Drop cookies, bar cookies, refrigerator cookies—all as tempting as the old favorite Oatmeal cookies.

Desserts

Tender pie crusts, crunchy topping for fruit "crisps". Perfect for tasty tortes and cobblers.

Meat Loaves and Hamburgers

Quaker Oats as a meat base holds the juices—cuts shrinkage—keeps the rich meaty flavor.

As an ingredient, Quaker Oats makes so many foods so good, you'll find a place for them on menus around the clock. It's smart business too, because Quaker Oats are low in cost, quick and easy to use.

Try Quaker Oats as an ingredient soon. For special quantity recipes, write for "Oats Ingredient Recipes", The Quaker Oats Company, Institutional Food Sales Department, Merchandise Mart, Chicago 54, Illinois.

QUAKER

THE QUAKER OATS COMPANY, CHICAGO 54, ILLINOIS


HEIN
TOMA
KETCH

GOOD FOOD TASTES BETTER WITH HEINZ

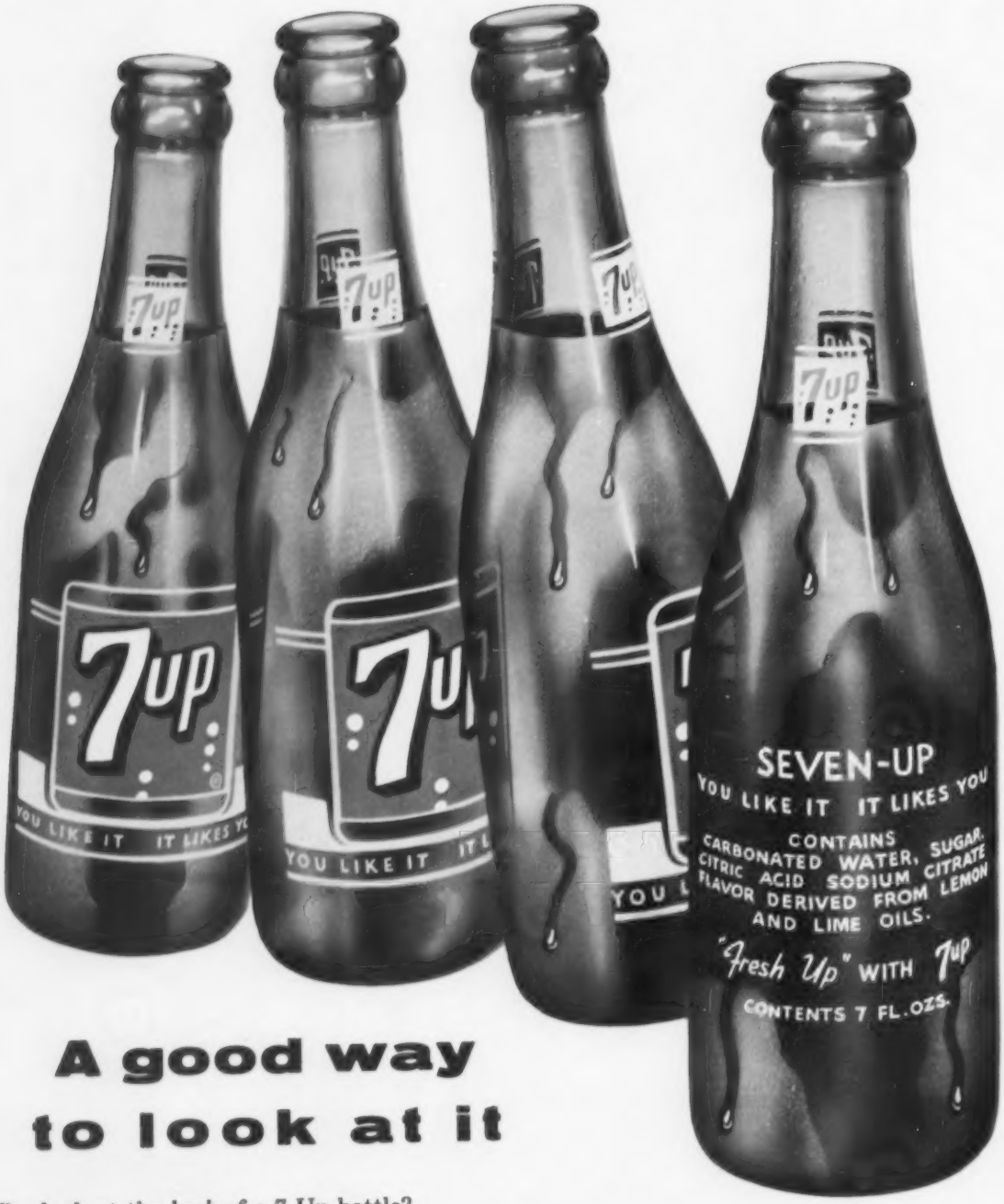
When people have a choice of ketchup and chili sauce—when they shop for their own table—their first choice is Heinz. When they eat away from home, Heinz is the brand they want to see.

The Heinz bottle is the sign of good eating. Its message: *only the best served here.*

What does it cost you to keep Heinz on the table? An average 20¢ worth of ketchup for every $100 in food served.

You can even get a special advertising allowance by keeping the Heinz bottle on the table or tray, where the public can see it—through a special offer called the Heinz Condimental Contract. You don't have it? Then get the facts about this money-saver at once. Ask your Heinz salesman or Heinz Distributor for complete details.

HEINZ 57 KETCHUP & CHILI SAUCE



A good way to look at it

Why look at the *back* of a 7-Up bottle?

Here's why. On the back of the bottle are listed all the ingredients of this sparkling, crystal-clear drink.

Such listing isn't *required*—but 7-Up is proud to do it. Proud to let you see what a pure and wholesome drink it is. Seven-Up is *so* pure and wholesome even tiny babies can have it. Seven-Up is truly the *All-Family* Drink.

If you want a real thirst-quencher . . .
If you hanker for a cool, clean taste . . .
If you want a quick, refreshing lift . . .

Nothing does it like Seven-Up!

Prescription to Perk up Patients... *at meal time*

Watch patients' spirits perk up when you serve them on bright, crisp Roylprints Place Mats and Tray Mats. Food looks more appealing . . . appetites are stimulated. Patients respond to the extra concern for their well-being . . . morale is boosted.

You'll like the extra measure of cleanliness and sanitation with Roylprints — for utensils never touch the bare tray. You use Roylprints once — then discard them. There's no extra work — no washing. No wonder so many top hospitals applaud them.

Roylprints are available in a wide variety of gay colors and charming designs — or if you wish — a design personalized with your hospital name and color choice. You'll be pleasantly surprised at the low cost. The whole story is yours for the mailing of the coupon . . . send it today.

Roylprints
PAPER PLACE MATS

Royal Lace Paper Works, Inc., Brooklyn 1, N. Y. *(A subsidiary of Eastern Corporation)*

Royal Lace Paper Works, Inc., Dept. MH-8
99 Gold Street
Brooklyn 1, New York

We'd like full details and samples of *Roylprints Paper Tray Mats* for hospital use.

Name .....

Name of Hospital .....

Address .....

City..... Zone..... State.....

Study Shows Detroit Hospitals Divided on Acceptance of Negro Patients and Physicians

DETROIT.—Thirty of 47 hospitals reporting in a survey conducted by the Detroit Commission on Community Relations indicated "significant numbers of Negro patient admissions," the commission's medical and hospital study committee reported here last month. Twenty of the reporting hospitals had segregated or partially segregated bed assignment policies, and 27 hospitals reported the bed assignment policy as integrated.

"Detailed racial statistics of births and deaths occurring in the 47 community hospitals indicate that the Negro citizen is receiving hospital care in roughly the same proportion that Negroes are a part of the total population of the area," the committee report said.

Of the 17 hospitals not normally admitting Negro patients, the committee said: "To account for the statistical findings in these hospitals, the committee concludes that either (1) the medical staff is not racially representative of the doctors practicing in the community, or (2) none of the doctors who practice in the hospital have patients who are Negro, or (3) doctors on the staff who do have Negro patients requiring hospitalization make other hospital arrangements for their care."

COMMITTEE'S RECOMMENDATIONS

Concluding that "a racially representative medical staff is vitally important if the hospital is to serve the entire community," and that "racial segregation has no place in present day community hospital operation," the committee recommended:

1. That hospital boards institute immediate review of medical staff appointment practices in their hospitals and take steps to see that staffs are representative of all professionally qualified doctors practicing in the community.

2. That boards review patient admission practices and bed utilization policies to determine if procedures are followed guaranteeing equal accommodation without discrimination or segregation for all patients.

3. That "the principle of community fund solicitation and grants be formalized to give protection to the fund giver, fund recipient and the community alike, and that as a precondition of grants specific plans and guarantees be required to demonstrate that not only will race not be a factor in the selection of the medical and nursing staff, or in training, but that all people will be served in the community institution without discrimination or segregation."

4. That "the community's prepayment plans for hospital care ensure equal accommodation to all people in the community without regard to race as a condition of the contractual arrangement with hospitals which are willing to receive hospitalization payment from white and Negro subscribers' prepayment funds."

A special committee on hospital medical staff appointments found that in 43 of the 47 hospitals it was stated that "race was not a factor" in determining eligibility of doctors for staff appointments. Twenty-three of the 47 hospitals reported one or more Negro doctors on the active medical staff.

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doctors on the medical staff of half the community's hospitals and their complete absence from the remainder," the committee report said.

Final recommendations included a request that the hospital council endorse the principle of appointments for medical staffs and medical training programs without regard for race, and that the Wayne County Medical Society establish a special committee to educate doctors and hospital trustees to support the "single standard of medical organization and training."

The medical and hospital study committee was appointed in 1952 to undertake a factual study of the participation of minority groups in medical and hospital services and facilities in the Detroit area, it was explained.

Hospital administrators in the community declined to comment on the report or the committee's recommendations. One administrator said that facts reported by the committee were probably accurate but interpretations were slanted to indicate hospitals were guilty of discriminatory practices, where no such practices existed, in his opinion.

Presbyterian-St. Luke's Hospital to Launch $7.5 Million Campaign

CHICAGO.—A $7.5 million building fund campaign will be launched in September by the newly merged Presbyterian-St. Luke's Hospital here, John P. Bent, president of the board of trustees, announced at a press conference here June 20.

The money will finance building plans including the expansion of the six-floor hospital pavilion now under construction to a height of 13 floors, with parking facilities; the rehabilitation of the present Presbyterian Hospital; a new hospital kitchen and laundry, and additional teaching and housing facilities for the nursing school. The two hospitals will provide a total of 900 beds.

In addition, the merged hospital is planning ultimately to provide a diagnostic clinic, a doctors' office building, and residential facilities for the house staff, graduate nurses, and technicians. All will be built adjoining the hospital.

Commission Accredits Arabian Hospital

NEW YORK.—Following a visit by Dr. Kenneth B. Babcock, chairman of the Joint Commission on Accreditation of Hospitals in the United States, the Dhahran Health Center of Arabian American Oil Company in Saudi Arabia has been fully accredited. The center is one of the few hospitals outside the United States and Canada to receive this full accreditation. Built at a cost of $3.5 million, the Dhahran Health Center includes a clinic, a 340 bed hospital, and a research section. An additional 67 bed medical wing and a 40 bed isolation ward are now under construction. When these additions are completed, the center will represent an investment of $6 million. Medical director of the center is Dr. Robert Page.

Louisville Head Named

LOUISVILLE, KY. — The Hospital Conference of Metropolitan Louisville elected Fred Veeder, administrator of Children's Hospital, president of the group at its annual meeting here. Other officers are: vice president, C. C. Weatherton, assistant administrator of Kentucky Baptist Hospital, and secretary-treasurer, Lewis Cook, assistant manager of Veterans Hospital.

William H. Markey Jr. Dies in Airline Crash

W. H. Markey Jr.

William H. Markey Jr., 46, director of financial management services for the Catholic Hospital Association of the United States and Canada, was killed June 30 in the TWA airline crash in Arizona. A member of the Catholic Hospital Association staff for the last three years, Mr. Markey at the time of his death was returning to association headquarters in St. Louis from Los Angeles, where he had been making arrangements for a forthcoming association conference.

Mr. Markey entered the hospital field in Pittsburgh in 1941 as manager of the Hospital Council of Western Pennsylvania and, later, as administrator of Shadyside Hospital. A graduate of Duquesne University, Pittsburgh, he was a public accountant for several years before joining the hospital council, and was qualified as a Certified Public Accountant.

Mass burial services for victims of plane crash in which Mr. Markey died.

From 1946 to 1952, Mr. Markey was a member of the headquarters staff of the American Hospital Association as specialist in hospital accounting, helping to prepare the manual "Uniform Hospital Statistics and Classification of Accounts."

Later, he served as a private financial consultant in Washington, D.C., and as consultant to a Public Health Service committee on fiscal studies, Commission on Financing Hospital Care.

Mr. Markey is survived by Mrs. Markey and five children, ranging in age from five to 14 years. "His death ended a distinguished career in the accounting field," said the Rev. John J. Flanagan, S.J., executive director of the Catholic Hospital Association. "His loss to the association is irreparable. He was a most talented and resourceful man in the area of hospital management and finance. He devoted and dedicated unselfishly all his great talents to his work in the Catholic Hospital Association."

A scholarship fund is being established for Mr. Markey's five children. Contributions to the fund may be sent to Rev. John J. Flanagan, S.J., Catholic Hospital Association, St. Louis.

$10 Million Needed for Interracial Hospital

CHICAGO. — A proposed 100 bed interracial hospital on the city's west side will be named in honor of the late Julius Rosenwald, Chicago philanthropist, Rev. Amos Carnegie revealed at the National Inter-Church Hospital Association's rally here June 29. The hospital will cost an estimated $10 million and will be located in the Medical Center.

The Rev. Mr. Carnegie, president of the association, said that the association "aims to invite every Protestant in the United States—57,000,000 of them—to pay $1 a year through his church to carry out the aims and purposes of the association."

Raymond Sloan Addresses French Hospital Group

PARIS, FRANCE. — Under the auspices of the publication *Techniques Hospitalieres,* founded in 1945 by Henri Thoillier, the fifth convention and exhibit of public health and hospital people was held here last month. Registration totaled approximately 1000, the highest yet recorded for this group, including representatives from some 21 countries.

Subjects presented by authorities in various areas of hospital and public health work included recent advances in medicine as well as in medical and surgical procedures, public health education and modern management technics. One afternoon was devoted to the design and the equipment of hospital and health buildings, and on the final day, designated as National French Hospital Federation Day, attention of registrants was directed to ways and means of humanizing the hospital, including the part played by the hospital physician, as well as the rôles of administrator and hospital personnel.

The United States was represented by a presentation of modern hospital service in this country by Raymond P. Sloan, president, the Modern Hospital Publishing Company.

An unusually interesting exhibit comprising the products of some 70 manufacturers of hospital equipment and supplies attracted much attention.

Hospitals Get Ford Grants for Research in Mental Health

NEW YORK.—Hospitals and medical schools were among the recipients of grants totaling $6,826,850 given by the Ford Foundation to research centers across the country to strengthen and extend research in mental health.

Hospitals and medical schools and the amounts they received are: University of California (Los Angeles), School of Medicine, $500,000; Cornell University, Medical College, $500,000; Johns Hopkins University, School of Medicine, $230,000; Massachusetts General Hospital, McLean Hospital Research Laboratory, Boston, $250,000; Menninger Foundation, Topeka, Kan., $350,000; University of Minnesota, Medical School, $238,400; Mount Sinai Hospital, Los Angeles, Psychiatric Research Institute, $250,000; State University of New York at Syracuse, College of Medicine, $274,050.

St. Louis Blue Cross Group Elects Officers

ST. LOUIS. — Group Hospital Service (the St. Louis Blue Cross Plan) elected Howard F. Baer, president of A. S. Aloe, St. Louis, to the office of president of the board of trustees at the board's annual meeting here June 20. He succeeds William C. B. Sodemann, who has served as president since December 1951.

Other officers elected were: vice presidents, Rev. Joseph B. Winter, diocesan director of Catholic Hospitals, St. Louis, and Dr. Joseph C. Peden, St. Louis; secretary, Rev. Carl C. Rasche, administrator, Evangelical Deaconess Hospital, St. Louis, and treasurer, William Sodemann. Members of the executive committee elected were: Dr. Frank R. Bradley, director of Barnes Hospital, St. Louis; Herbert S. Wright, administrator of Southeast Missouri Hospital, Cape Girardeau; John I. Rollings, president of the Missouri Federation of Labor, St. Louis, and Dr. M. K. Underwood, Rolla.

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New Commission to Continue Medical Statistical Program of Southwestern Michigan Council

(*Continued From Page* 55)

Dr. Crosby. "The establishment of this commission, with sponsorship of three national organizations, makes possible the broadening of the work and will thus extend the benefit to many other hospitals and also permit a more thorough evaluation of its applicability on a national scale."

With 23 member hospitals of the council participating, the Professional Activity Study of the Southwestern Michigan Hospital Council developed a simplified method of collecting and reporting medical statistics for hospitals, Dr. Slee explained.

Under this system, a single sheet reporting the medical diagnosis and treatment was completed for every patient discharged from each member hospital. These records were forwarded to a central service bureau, where they were tabulated by machine and returned to the hospital as summarized records permitting study and comparison of the performance of individual doctors on the staff, and comparison of results among hospitals.

Last year, the Professional Activity Study handled 144,000 discharges, Dr. Slee said.

"Organization of the commission will permit us to extend the service to other hospitals, and to experiment with services in other areas of medical and hospital interest," Dr. Slee said.

Growth of the service under the new commission will be gradual, however, it was explained. "The program should expand very slowly," Dr. Slee said, "so that we may work intensively in helping participating hospitals utilize the information available to them and strive constantly for the kinds of studies and data that will be of maximum usefulness."

The Michigan experience indicated that the service could be furnished at a cost within the reach of small, community hospitals and that in many cases mechanization of medical statistical procedures may actually save hospitals money, Dr. Slee reported.

V.A. Defines Eligibility for Hospital Benefits

WASHINGTON, D.C.—Veterans who served only during peacetime are not entitled to Veterans Administration hospitalization, it was announced here recently.

In an official release, the V.A. stated that peacetime veterans may be admitted to V.A. hospitals only under two conditions: (1) if honorably discharged for a disability incurred in line of duty; (2) if receiving V.A. compensation for a service-connected or service-aggravated disability.

Peacetime service, as defined by Congress, is any period of active service that occurred before or after a war and does not extend into a war period, *i.e.* service on or after Feb. 1, 1955; between Dec. 31, 1946, and June 27, 1950; between Dec. 12, 1918, and Dec. 7, 1941, and between July 4, 1902, and April 6, 1917.

Special eligibility requirements apply to peacetime veterans who have been retired from active peacetime service. Veterans in this category should check their eligibility with the V.A. before applying the release stated.

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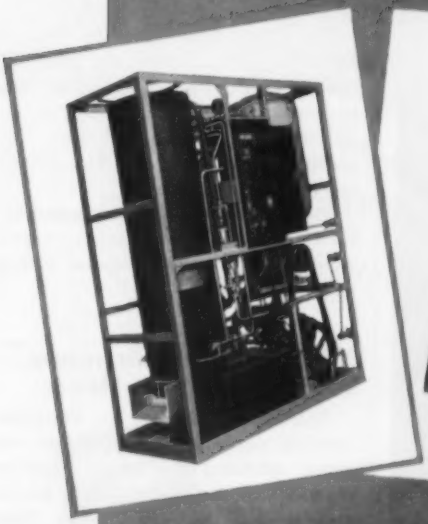

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N.Y. Code Provides for New Ethical Standards for Proprietary Hospitals

NEW YORK.—A new code providing for the establishment of professional and ethical standards by the medical board of each New York City proprietary hospital will go into effect here October 1.

Dr. Basil C. MacLean, Commissioner of Hospitals and chairman of the Board of Hospitals, announced that these standards would include: requirements for professional consultations; preoperative examination of patients by the attending physician prior to major surgery (except in emergencies); completion of necessary laboratory examination prior to surgery; placement of a comprehensive report in the patient's record following surgery; and examination of surgical specimens, amputated parts and other tissues removed from a patient by the pathologist.

Major provisions of the new code are:

To establish stricter control by the Department of Hospitals over proprietary hospitals and to prohibit wherever possible unreasonable or unwarranted charges.

To require each such hospital to establish a medical board whose members shall include a qualified internist, surgeon, pathologist, anesthesiologist, roentgenologist and obstetrician if maternity service is provided, and a pediatrician if children are cared for in the hospital.

The medical board is to meet at least once every three months.

Two-Year Benefit Program Announced by Illinois Blue Cross-Blue Shield

CHICAGO. — Blue Cross and Blue Shield plans in Illinois have announced a new program to provide as much as two years of extended hospital and medical care benefits for catastrophic sickness or accident, Robert T. Evans, executive director, announced here.

Blue Shield and Blue Cross members in firms with 100 or more employes are entitled to the extended benefits when more than 75 per cent of the persons enrolled in these programs take extended benefits.

Mr. Evans explained that the employe becomes eligible for extended benefit protection on his 121st day of hospitalization and as long as he is hospitalized, up to 730 days. The additional cost is less than $1 a month for family membership.

Mars, Inc., Chicago candy manufacturer, is the first company to enroll its employes in this program, it was announced.

Michigan Administrators Elect Conference Heads

LUDINGTON, MICH. — Forty-five hospital administrators, assistants and guests attended the annual "holiday meeting" of the West Central Michigan Hospital Conference here June 20 as guests of the Chesapeake and Ohio Railroad.

A brief business meeting was held at which the following officers were elected: president, Patrick Monaghan, director of the Ionia Memorial Hospital, Ionia; vice president, Mary Patterson, assistant director, Blodgett Memorial Hospital, Grand Rapids, and secretary-treasurer, Donald Walchenbach, assistant director, Butterworth Hospital, Grand Rapids. Ella Longley, administrator of Pauline Stearns Hospital, Ludington, is outgoing president.

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Back row: (left to right) George De-Lange, Dr. Pedro N. Acosta (special student), Alfred Muller Jr., Daniel H. Fletcher, Keith O. Taylor (associate director), Richard J. Stull (director). Front row: (left to right) Joseph E. Mulroy, Stuart Marylander, Manuel Perez, Robert M. Cohn, Frederic W. Trader Jr., and Ross C. Ledbetter.

N.Y. Hospital Employes Boycott Meals in Protest

NEW YORK.—Employes of 28 municipal hospitals here staged a boycott of hospital dining rooms on June 23 to protest a city plan requiring them to pay for their meals. More than 13,000 hospital workers were involved in the demonstration which the New York City Hospital Department termed "80 per cent effective."

Most of the 33,000 workers have been given one or more free meals on the job. The new plan, effective July 1, required employes to pay 25 per cent of the total cost of their meals (10 cents for breakfast, 15 for lunch, 20 for dinner), and by 1959, all employes are to pay the full cost (40 cents for breakfast, 60 for lunch, 80 for dinner).

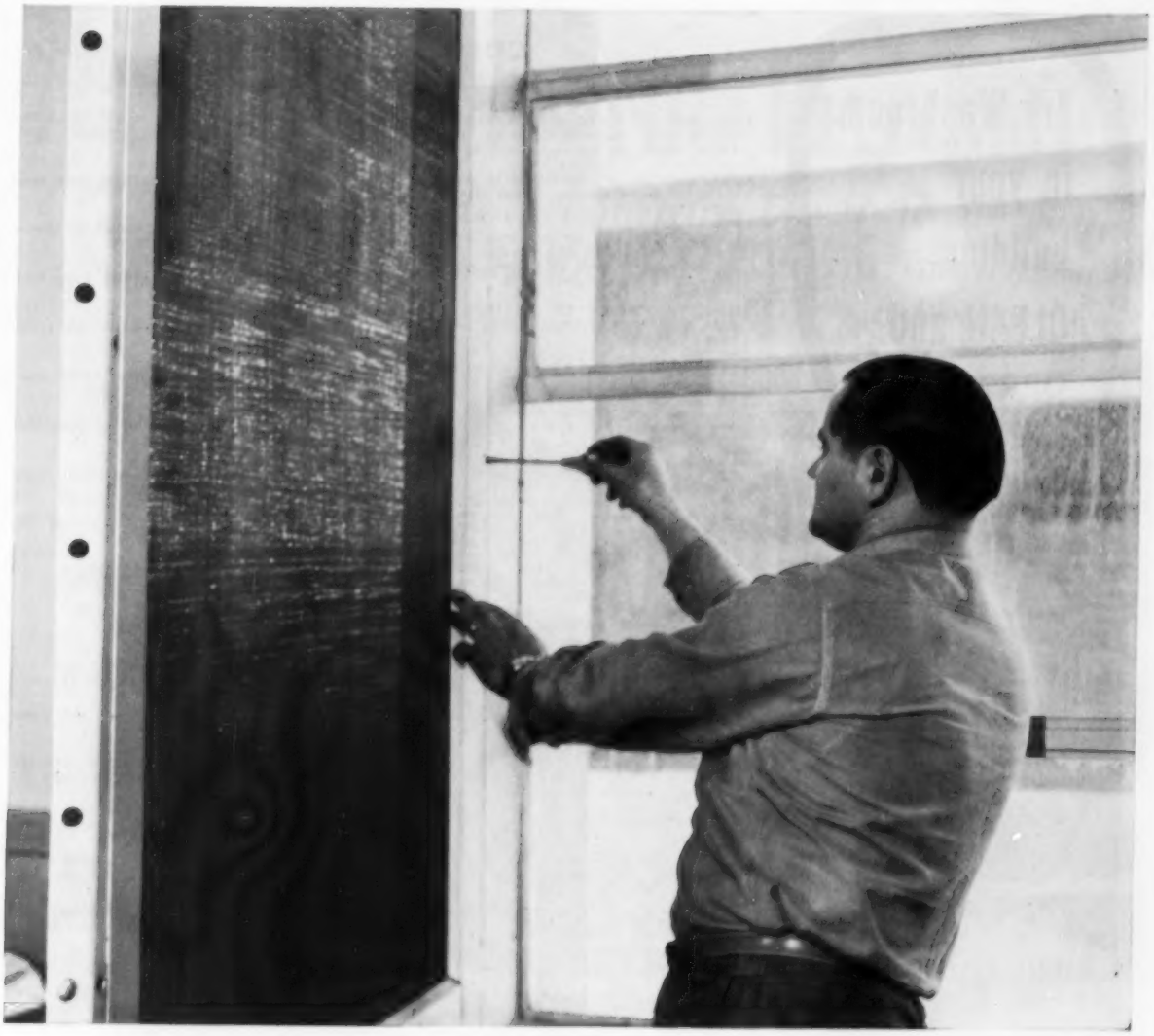
The one-day boycott was organized by City Employes Union Local 237, International Brotherhood of Teamsters, and did not interrupt medical service at the hospitals.

The meal-charge plan is part of the city's new career and salary plan which became effective July 1, 1954, granting pay raises and annual increments to hospital employes.

The city hopes to save $2 million through the meal-charge plan, which was scheduled to go into effect July 1, 1955, and postponed for one year by the Board of Estimate after employes protested. Similar plans for the Department of Correction and the Board of Education were abandoned after protests.

96 Corpsmen Graduate

BETHESDA, MD. — Ninety-six senior medical and dental hospital corpsmen were graduated from the U.S. Naval School of Hospital Administration, National Naval Medical Center, here June 22.



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COMING EVENTS

AMERICAN ASSOCIATION OF HOSPITAL ACCOUNTANTS, Northern California Chapter, Palace Hotel, San Francisco, Sept. 6, 7.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Annual Meeting, Palmer House, Chicago, Sept. 15-17.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS INSTITUTES: 24th Chicago, University of Chicago, Sept. 4-14; 7th Chicago Advanced, University of Chicago, Sept. 10-14.

AMERICAN COLLEGE OF SURGEONS, CLINICAL CONGRESS, Fairmont Hotel, San Francisco, Oct. 8-12.

AMERICAN HOSPITAL ASSOCIATION, Annual Convention, Palmer House, Chicago, Sept. 17-20; Midyear Conference for Presidents and Secretaries of State Hospital Associations, Palmer House, Chicago, Feb. 4, 5.

AMERICAN HOSPITAL ASSOCIATION INSTITUTES: Hospital Pharmacy, University of Chicago, Chicago, Aug. 20-24; Evening and Night Nursing Service, Adolphus Hotel, Dallas, Oct. 1-4; Medical Record Library Personnel, Hotel Jefferson, Richmond, Va., Oct. 15-19; Administrators' Secretaries, Edgewater Beach Hotel, Chicago, Oct. 22-26; Operating Problems for Small Hospitals, Vermont Hotel, Burlington, Vt., Oct. 25, 26; Hospital Auxiliary Leadership, Cleveland, Nov. 1, 2; Nursing Service Administration, Cincinnati, Nov. 5-9; Operating Problems for Small Hospitals, Winnipeg, Nov. 1, 2; Physical Therapy, San Francisco, Nov. 5-9; Dietary Department Administration, Denver, Nov. 12-16; Supervisory Training Workshop, Montreal, Nov. 24-30; Hospital Safety Seminar, Chicago, Nov. 24-30; Maintaining Standards of Patient Care in Hospital Systems, Hershey, Pa., Nov. 28-30. Obstetrical Nursing Service Administration, Toronto, Dec. 3-6; Methods Improvement, Highland Park, Ill., Dec. 3-7.

ARIZONA HOSPITAL ASSOCIATION, Westward Ho Hotel, Phoenix, Nov. 15-17.

ASSOCIATED HOSPITALS OF ALBERTA, MacDonald Hotel, Edmonton, Oct. 16-18.

ASSOCIATED HOSPITALS OF MANITOBA, Royal Alexandria Hotel, Winnipeg, Oct. 29-Nov. 1.

CALIFORNIA HOSPITAL ASSOCIATION, San Jose, Oct. 24-26.

COLORADO HOSPITAL ASSOCIATION, Broadmoor Hotel, Colorado Springs, Nov. 6, 7.

CONNECTICUT HOSPITAL ASSOCIATION, South New England Telephone Company Auditorium, New Haven, Nov. 15.

FLORIDA CHAPTER OF THE AMERICAN ASSOCIATION OF HOSPITAL ACCOUNTANTS, Institute and Workshop, Daytona Plaza Hotel, Daytona Beach, Oct. 17-19.

FLORIDA HOSPITAL ASSOCIATION, Jacksonville, Nov. 29, 30.

IDAHO HOSPITAL ASSOCIATION, Hotel Boise, Boise, Oct. 22, 23.

ILLINOIS HOSPITAL ASSOCIATION, Hotel Abraham Lincoln, Springfield, Dec. 6, 7.

INDIANA HOSPITAL ASSOCIATION, Student Union Building, University of Indiana Medical Center, Indianapolis, Oct. 24, 25.

INTERNATIONAL CONGRESS ON MEDICAL RECORDS, Shoreham Hotel, Washington, D.C., Oct. 1-5.

KANSAS HOSPITAL ASSOCIATION, Baker Hotel, Hutchinson, Nov. 15, 16.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Hotel Shoreham, Washington, D.C., Oct. 31-Nov. 2.

MINNESOTA HOSPITAL ASSOCIATION, Hotel St. Paul, St. Paul, Nov. 9.

MISSISSIPPI HOSPITAL ASSOCIATION, 25th annual convention, Hotel Edwards, Jackson, Oct. 18, 19.

MONTANA HOSPITAL ASSOCIATION, Florence Hotel, Missoula, Oct. 10-12.

NATIONAL SOCIETY FOR CRIPPLED CHILDREN AND ADULTS, Hotel Statler, Washington, D.C. Oct. 28-31.

NEBRASKA HOSPITAL ASSOCIATION, Hotel Fontenelle, Omaha, Oct. 25, 26.

OKLAHOMA HOSPITAL ASSOCIATION, Skirvin Hotel, Oklahoma City, Nov. 8, 9.

ONTARIO HOSPITAL ASSOCIATION, Royal York Hotel, Toronto, Oct. 22-24.

OREGON ASSOCIATION OF HOSPITALS, Hotel Senator, Salem, Oct. 8, 9.

SASKATCHEWAN HOSPITAL ASSOCIATION, Bessborough Hotel, Saskatoon, Oct. 24-26.

VERMONT HOSPITAL ASSOCIATION, Long Trail Lodge, Pico Peak, Rutland, Oct. 17, 18.

VIRGINIA HOSPITAL ASSOCIATION, Hotel Roanoke, Roanoke, Nov. 16, 17.

WASHINGTON HOSPITAL ASSOCIATION, Chinook Hotel, Yakima, Oct. 10, 11.

WEST VIRGINIA HOSPITAL ASSOCIATION, Hotel Chancellor, Parkersburg, Oct. 11-13.

1957

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Palmer House, Chicago, Feb. 27-Mar. 1.

ASSOCIATION OF WESTERN HOSPITALS, Statler Hotel, Los Angeles, May 6-9.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Hotel Roanoke, Roanoke, Va., April 4, 5.

CATHOLIC HOSPITAL ASSOCIATION, Statler Hotel, Cleveland, May 27-30.

HOSPITAL ASSOCIATION OF PENNSYLVANIA, Convention Hall, Atlantic City, N.J., May 22-24.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N.J., May 22-24.

MID-WEST HOSPITAL ASSOCIATION, Hotel President, Kansas City, Mo., April 10-12.

NATIONAL ASSOCIATION FOR PRACTICAL NURSE EDUCATION, Ambassador Hotel, Atlantic City, N.J., April 29-May 3.

NEW ENGLAND HOSPITAL ASSEMBLY, Statler Hotel, Boston, Mar. 25-27.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, April 29-May 2.

UPPER MIDWEST HOSPITAL CONFERENCE, Auditorium, Minneapolis, May 15-17.

Boston Conferences Will Be Repeated

BOSTON. — A repeat performance of a series of instructional conferences will be presented here on October 29 and 30 for the benefit of more than 1200 staff members of New England hospitals who were turned away from the original conferences held during the New England Hospital Assembly in March. Abbie E. Dunks, chairman of the N.E.H.A. public relations committee, announced that the same instructors and the same subject matter will be used in the October series.

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Honors Given to Six Northwestern Graduates

EVANSTON, ILL. — Special awards were given to six graduates of Northwestern University's course in hospital administration at the June commencement exercises here. All received master's degrees.

Arnold E. Mouish received the Malcolm T. MacEachern Award, given to a student with high academic standing who shows unusual promise of achievement in hospital administration.

Robert Kelly Dean was given the Mary H. McGaw Award. William Elliott Jones and Glenn Ellis Morris divided the Fred Geck Award for their graduate study projects.

Roy F. Erickson and E. Dean Grout shared the American Surgical Trade Association Award for high scholastic standing.

Frank Rhatigan (right) presents the A.S.T.A. awards to E. Dean Grout, at left, and Roy F. Erickson, in center.

Elect Council Officers

BROOKLYN, N.Y. — The Hospital Council of Brooklyn, Long Island and Staten Island has elected the following officers for 1956-57: president-elect, Sydney L. Moody, Carson C. Peck Memorial Hospital; president, George N. Johnson, Evangelical Deaconess Hospital; vice president, Vernon Stutzman, Methodist Hospital of Brooklyn; secretary, Sister M. Rose Virginia, O.P., St. Catherine's Hospital, and treasurer, Kathryn R. Dooley, Caledonian Hospital.

Stohler Is President-Elect of Tennessee Association

(*Continued From Page* 160)

Dr. Bradley, past president of the American Hospital Association, added that he is a "strong advocate of the voluntary hospital system. Socialized medicine should be used when, and only when, it is absolutely necessary."

"But," he added, "I cannot disregard the possibility that some conditions warrant socialization."

Other officers elected are: first vice president, William B. Barnhart, administrator of Mary County Hospital, Columbia; second vice president, Harold L. Peterson, administrator of Baroness Erlanger Hospital, Chattanooga; treasurer, Frank Magoffin, Oakville Memorial Sanatorium, Memphis.

Trustees elected are: James M. Crews, administrator, Methodist Hospital, Memphis; Gene Kidd, administrator, Mid-State Baptist Hospital, Nashville, and James E. Ferguson, University of Tennessee Memorial Research Center and Hospital, Knoxville.

The Tennessee Association of Medical Record Librarians, meeting in conjunction with the hospital association, named Gertrude McCalip of Baptist Hospital, Memphis, president-elect. Jerry Weatherly, Holston Valley Community Hospital, Kingsport, became president during the meeting. Other officers elected are: vice president, Sister Agnes Borgia, Memorial Hospital, Chattanooga, and councilor, Patty Taylor, Baptist Hospital, Memphis.

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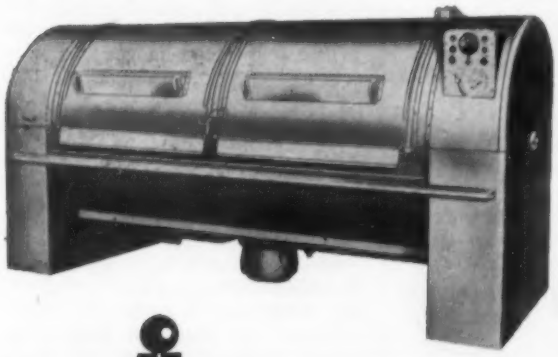

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TB Group Hears Reports on Major Problems of Tuberculosis Treatment

NEW YORK.—Communicable disease is no longer a major cause of death among nurses, according to a U.S. Public Health Service study reported to the 52d annual meeting of the National Tuberculosis Association here. The study further indicates that the greatest mortality risks for nurses today are not directly related to their professional services.

Andrew Theodore of the Public Health Service reported on the survey which covered 26,000 nurses, studied over a period of 10 years. Of 96 deaths that occurred in this group, 35 were from violent causes—accidents, suicides and homicide. Fourteen of these, the largest single number, were caused by motor vehicle accidents; overdoses of barbituates accounted for seven, suicides for six, monoxide poisoning for two, murder for one.

Tuberculosis, once a leading cause of death in the nursing profession, accounted for only three deaths. Poliomyelitis was responsible for seven deaths. Malignant tumors and cardiovascular-renal diseases ranked after violent causes as leading causes of death.

Other speakers at the association's convention named nonhospitalized tuberculosis patients as the major problem in controlling the disease today. More outpatient departments and clinics are essential for the detection and treatment of nonhospitalized cases, said Dr. Edward X. Mikol, general director of tuberculosis hospitals for the New York State Department of Health.

Nonhospitalized patients, both known and unknown, are the source of infection for the more than 80,000 new cases reported each year in this country, Dr. Mikol pointed out.

Ruth Fisher, R.N., director of the department of public health nursing, National League for Nursing, stated that hospitals or sanatoriums that have cared for a patient should offer continuing consultation service without charge to the family physician or clinic physician after the patient's discharge.

The use of hospital clinic facilities to provide continuous, consistent therapy for previously hospitalized patients was recommended by Dr. Frances Lansdown of Bellevue Hospital, New York. During the last two and one-half years, patients who began drug treatment on the wards of Bellevue and then were transferred to home care with clinic supervision fared better than those who were treated initially in the clinic or were accepted from other institutions, Dr. Lansdown reported.

The effectiveness of drugs now available for treating tuberculosis and refinements in surgery were also described at the meeting. Dr. James E. Perkins, N.T.A. director, stated that the death rate from tuberculosis had been cut almost 75 per cent in the last 10 years. However, he said that the disease still causes more deaths than all other infectious diseases combined. Nearly 400,000 people in this country have active cases, he said, and approximately 150,000 of them are unreported to health authorities.

Some 2500 physicians, medical research workers, health educators, nurses and medical social workers attended the four-day meeting, which included sessions of the American Trudeau Society, the N.T.A.'s medical section, and the National Conference of Tuberculosis Workers.

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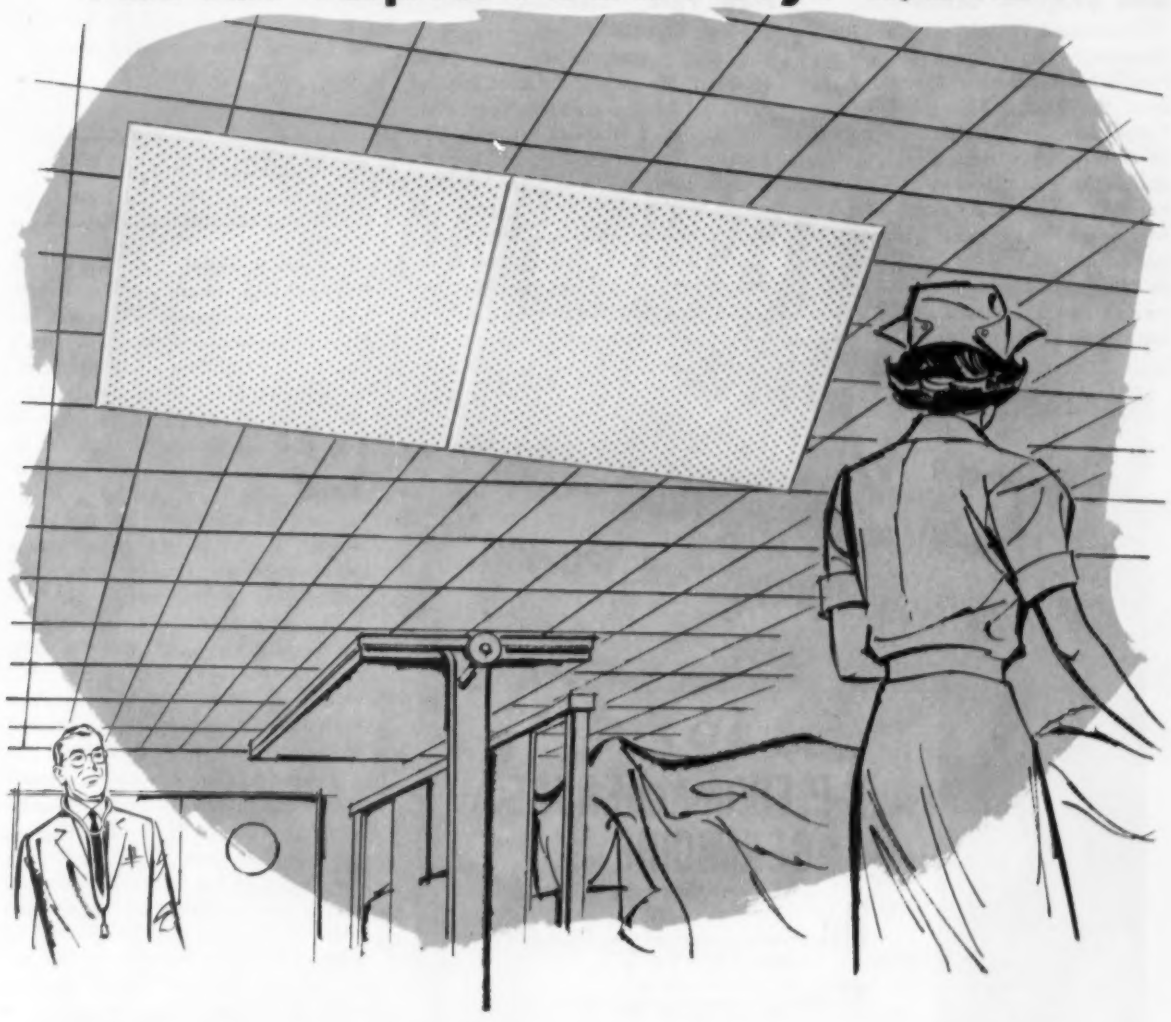

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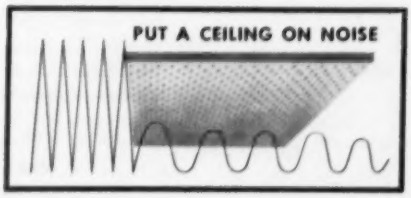

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Mental Health Group Gets $25,000 Grant

CAMBRIDGE, MASS. — The Joint Commission on Mental Illness and Health has received a $25,000 grant from the Smith, Kline and French Foundation of Philadelphia to support its three-year national mental health study. The grant, received at the commission's headquarters here June 24, will be used to appraise present mental health knowledge and methods and find new approaches to solve the mental illness problem or to implement existing methods.

Mildred Lapham Heads New York Personnel Group

NEW YORK.—Mildred S. Lapham, personnel director of the New York Hospital, Manhattan, has been elected president of the Greater New York Association of Hospital Personnel Executives for 1956-57. She succeeds Robert Beaubien of St. Luke's Hospital, Manhattan. Other officers are: vice president Alvin Miller, Beth-Israel Hospital, Manhattan, and secretary, Dorothy T. Jackson, Meadowbrook Hospital, Hempstead.

Members-at-large elected were: Pauline Saifer, Jewish Chronic Disease Hospital, Brooklyn, and John W. Cogger, Hospital of Rockefeller Institute for Medical Research, Manhattan.

ABOUT PEOPLE

Continued From Page 80

William R. Howes, administrator of Evanston Community Hospital, Evanston, Ill., since October 1954, will become administrator of St. Christopher's Hospital for Children, Philadelphia, effective October 1. Previously, Mr. Howes served as assistant director of Mount Sinai Hospital, Chicago, and as administrator of Chicago Physicians and Surgeons Hospital. He is studying hospital administration at Northwestern University. Mr. Howes is a graduate of the British Army Staff College in Quetta, India. He had charge of military hospital and personnel shipping movements in India while a major in the British army. Mr. Howes was formerly assistant for Price Waterhouse and Company, certified public accountants, Philadelphia.

Richard L. Durbin, who is currently completing his residency in hospital administration at Methodist Hospital, Gary, Ind., as part of his work on a master's degree in business administration at the University of Chicago, has been named assistant administrator of City of Memphis Hospitals, Memphis, Tenn. He succeeds **Joseph Mackey,** who has accepted a similar position at E. H. Crump Memorial Hospital, Memphis.

Arthur C. Forche, former acting superintendent of Beyer Memorial Hospital, Ypsilanti, Mich., has been appointed superintendent there. He succeeds **Alfred Kurtz,** who resigned.

Fred Hunt, superintendent of Olympic Clinic, Clallam County Hospital District No. 1, Forks, Wash., has accepted the duties of administrator of Santiam Memorial Hospital, Stayton, Ore. **Bertha Hall** is acting as superintendent until Mr. Hunt's successor is named.

Gray Bingham, administrator of Glenn General Hospital, Willows, Calif., has resigned after a controversy with the Glenn County board of trustees. Mr. Bingham was hired March 1 to replace **George Waddill,** who resigned.

Dr. Thomas F. Sheehy Jr., chief of

service and assistant medical director of Firland Sanatorium, Seattle, has been named acting medical director to succeed **Dr. Daniel W. Zahn,** 45, who died May 6.

Roy C. Stephenson, administrator of the Idaho Falls Latter-Day-Saints Hospital, Idaho Falls, Idaho, has been appointed administrator of the Lowell General Hospital, Lowell, Mass., succeeding **Paul J. Spencer.** Mr. Stephenson is a former president of the Idaho Hospital Association and vice president, Association of Western Hospitals.

Elmer O. Massmann, administrator of French Hospital, San Francisco, has accepted the post of associate director of Stanford-Palo Alto Hospital, Palo Alto, Calif. The former president of the San Francisco Hospital Conference, Mr. Massmann will be succeeded in the presidency by **Sister Mary Philippa,** administrator of St. Mary's Hospital, San Francisco.

Jeanette Edlund, R.N., has been appointed superintendent of Skagit General Hospital, Mount Vernon, Wash., succeeding **Dorothy Ross.** Mrs. Edlund was graduated from Providence Hospital School of Nursing, Everett, Wash.

Sanford Robinson, administrator of the Winter Park Memorial Hospital, Winter Park, Fla., has resigned.


Arnold Mouish

Arnold E. Mouish, personnel officer at the Veterans Administration Hospital, Louisville, Ky., has assumed the duties of special assistant to the manager at V.A. Hospital, Northport, Long Island, N.Y. Mr. Mouish received his master's degree in hospital administration at Northwestern University in June and was awarded the Malcolm T. MacEachern medal for exceptional achievement.

Harold W. Wade, administrator of Clinton General Hospital, Clinton, Mo., has assumed the duties of administrator of the Atchison Hospital, Atchison, Kan. He succeeds **Robert Lyons,** who resigned.

Dr. Kenneth P. Payne, director of the acute and contagious disease ward of the Army Hospital, Fort Eustis, Va., has been named the medical superintendent at Pine Camp Hospital, Richmond, Va.

Mrs. Lewis M. Miller, director of Rowan Memorial Hospital, Salisbury, N.C., for nearly 25 years, has resigned her position there.

Dr. K. K. Sherwood, medical director of King County Hospital System, Seattle, for the last four years, has been named general superintendent, succeeding **Dr. Edwin S. Bennett,** who retired July 1 after more than 10 years as superintendent.


Jerome Stewart

Jerome Gregory Stewart has been appointed assistant administrator of the Staten Island Hospital, Staten Island, N.Y. He succeeds **Thomas P. Dailey,** whose resignation was reported in these columns in the April issue. Mr. Stewart is a graduate of Columbia University's course in hospital administration and served his administrative residency at the Long Island College Hospital, Brooklyn, N.Y.

Elizabeth Baethke, laboratory technician at Kewanee Public Hospital, Kewanee, Ill., has been named administrator there. She succeeds **Mrs. Elbert Peterson.**

Edna B. Pomeroy, R.N., former head of the Frances E. Parker Memorial

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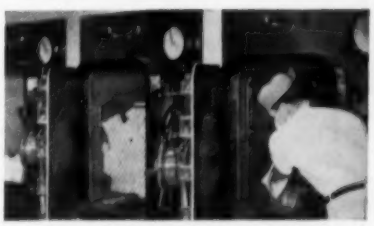

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Home, New Brunswick, N.J., will assume the duties of administrator of Stephens Memorial Hospital, Norway, Maine, when it is opened for use in December. Mrs. Pomeroy is former supervisor of Glens Falls Hospital, Glens Falls, N.Y., and was superintendent of nurses and assistant to the administrator of Middlesex General Hospital, New Brunswick, N.J., prior to her work with the Parker Home.

Harry D. Cranston Jr., business manager of Alta Bates Community Hospital, Berkeley, Calif., has been appointed assistant administrator there.

Dr. Benjamin A. Cockrell has resigned as manager of Veterans Hospital No. 88, Memphis, Tenn.

Jerry L. Durr, currently completing work for his master's degree in hospital administration at Northwestern University, has been appointed administrative resident at University Hospital, Jackson, Miss.

Eugene Olszewski, formerly business manager of Mountain View Sanatorium, Tacoma, Wash., has assumed the duties of administrator of Rowley General Hospital, Mount Vernon, Wash. He succeeds **Willis Parr,** who has been appointed administrator for Skagit County Public Hospital District No. 1, which is planning to construct a 75 bed hospital in Mount Vernon.

Harry S. Cutler, administrator of the Montfort Jones Memorial Hospital, Kosciusko, Miss., has been named administrator of Riley's Hospital, Meridian, Miss. Mr. Cutler is president-elect of the Mississippi Hospital Association.

Dewitt Allsup has assumed the duties of manager of Shamrock General Hospital, Shamrock, Tex., succeeding **Don Curl.** In addition to his managerial duties, he will handle all laboratory work of the hospital.

Dr. Roy Edwards has resigned as superintendent of Western State Hospital, Hopkinsville, Ky.

Richard W. Sellers has been appointed assistant administrator of Children's Memorial Hospital, Chicago.

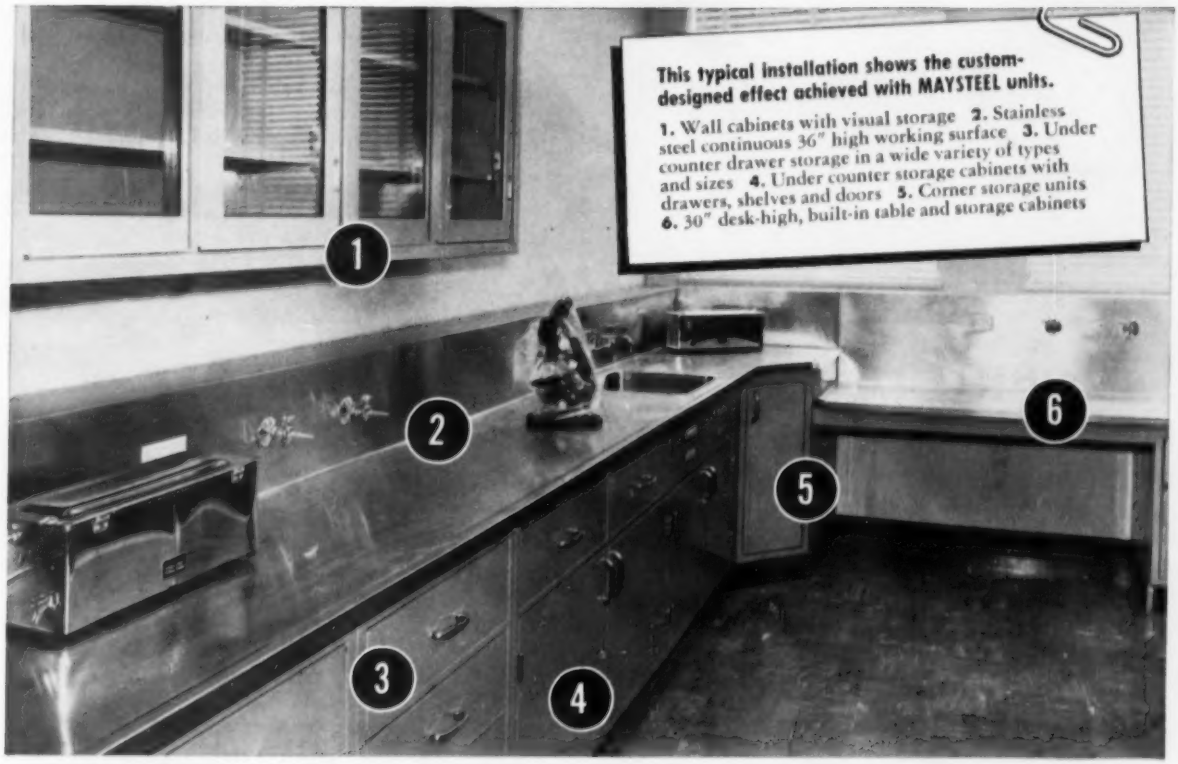
Roy Stadler has been named administrator of Ray County Memorial Hospital, Richmond, Mo. Mr. Stadler is a graduate of Northwestern University's course in hospital administration.

Eugene C. Hawkins is the new full-time director of the Montgomery (city-county) Joint Public Charity Hospital Board, Montgomery, Ala., an organization created to provide for the indigent. Mr. Hawkins was formerly administrator of Professional Center Hospital, Montgomery.

Herman F. Zimoski has assumed the duties of assistant administrator and business manager of Kaiser Foundation Hospital, Fontana, Calif. Mr. Zimoski was formerly administrator of Door County Memorial Hospital, Sturgeon Bay, Wis.

Forrest A. Brower has been named administrative assistant at East Orange General Hospital, East Orange, N.J. Mr. Brower is a recent graduate of the Columbia University School of Public Health and Administrative Medicine. He was formerly supply and assistant legal officer at Air Force Far Eastern Headquarters, Tokyo.

George Adams and **William Peters,** administrative assistants at Methodist Hospital of Brooklyn, N.Y., have been appointed assistant directors of the hospital. Mr. Adams is a graduate of the course in hospital administration at Columbia University and also served his residency at Methodist Hospital. He had formerly been associated with the Maimonides Hospital of Brooklyn, N.Y. He is a nominee of the American College of Hospital Administrators. Mr. Peters was formerly associated



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Joseph Sherber has been appointed administrative assistant at New York Hospital, New York. Mr. Sherber holds an M.S. degree in administrative medicine from Columbia University and served his administrative residency at New York Hospital.

Charles G. Lohr, member of the administrative staff at Barnes Hospital, St. Louis, has been named administrator of Lawrenceville County Memorial Hospital, Lawrenceville, Ill.

John D. Bosler, assistant manager of the Veterans Administration Hospital, Albany, N.Y., has been appointed manager of the V.A. Hospital at Syracuse, N.Y. Mr. Bosler will succeed **Dr. George O. Pratt,** who has resigned.

Audrey Webster, R.N., has assumed the duties of superintendent of Gaylord Community Hospital, Gaylord, Minn. Miss Webster is a graduate of Abbott Hospital School of Nursing, Minneapolis, and has served with the Gaylord Hospital since 1952. She succeeds **Agnes Offerstein.**

Paul Flanagan is the new administrator of the King's Daughters' Hospital, Staunton, Va. Mr. Flanagan was the former assistant administrator at the Middletown Hospital, Middletown, Ohio. He is a graduate of the Medical College of Virginia's course in hospital administration, and a member of the American College of Hospital Administrators. He succeeds **John C. Hess,** who has accepted a similar position in Midland, Tex.

Paul K. Potter has been appointed administrator of Daviess County Hospital, Washington, Ind. Mr. Potter was formerly administrative assistant at Wesley Hospital, Wichita, Kan. He is a graduate of Northwestern University's course in hospital administration.

Matthew J. Ustas has assumed the duties of administrator of the Hunt Memorial Hospital, Danvers, Mass., to succeed **Helen M. Hamilton,** who has retired. Mr. Ustas is the former administrator of the Presque Isle General Hospital, Presque Isle, Maine.

James Conte has been named assistant administrator of the Jacksonville State Hospital, Jacksonville, Ill. Mr. Conte, a graduate of Northwestern University's course in hospital administration, is former administrative assistant of East Moline State Hospital, East Moline, Ill.

John R. Moore has been named administrator of Cowell Memorial Hos-

pital (University of California) in Berkeley, Calif. He succeeds **Rodney Lamb,** who has accepted the position of assistant administrator of Santa Barbara Cottage Hospital, Santa Barbara, Calif. Mr. Moore was formerly administrator of Trinity General Hospital, Weaverville, Calif.

Sister Catherine Ellen, assistant administrator of St. Francis Hospital, Trenton, N.J., has assumed the duties of administrator there. She replaces **Sister M. Pierre,** who has been transferred to St. Joseph's Hospital, Baltimore.

Walter Noakes, administrator of Wewoka Memorial Hospital, Wewoka, Okla., has resigned his duties there to attend Oklahoma City University.

Richard L. Olsen has succeeded **Stanley N. Allen** as assistant administrator of Presbyterian Hospital Center, Albuquerque, N.M. Mr. Olsen, who recently completed his administrative residency at Vancouver General Hospital, Vancouver, B.C., is a graduate of the University of Minnesota's course in hospital administration. Mr. Allen has accepted the position of clinic manager of the Lenont-Peterson Clinic, Virginia, Minn.

W. J. Bishop, administrator of Lee County Memorial Hospital, Bishopville, S.C., has been appointed business manager of Martin County Hospital, Stuart, Fla., to replace **Charles A. Johnson,** who has resigned.

Robert Brandow

Robert H. Brandow, formerly personnel director at Methodist Hospital, Gary, Ind., has been appointed assistant administrator of Lake County Memorial Hospital, Painesville, Ohio. Mr. Brandow holds a degree in hospital administration from Northwestern University and has just completed his administrative residency at Aultman Hospital, Canton, Ohio. He is a member of the American Association of Hospital Accountants.

Dr. Jackson H. Friedlander, chief of the residency and internship program in the Veterans Administration central office, Washington, D.C., has been named manager of the V.A. Hospital, Big Spring, Tex., succeeding **Ira G. Sims,** who has been transferred to the V.A. Center, Whipple, Ariz. Dr. Friedlander is a fellow of the American College of Physicians.

(*Continued on Page* 190)

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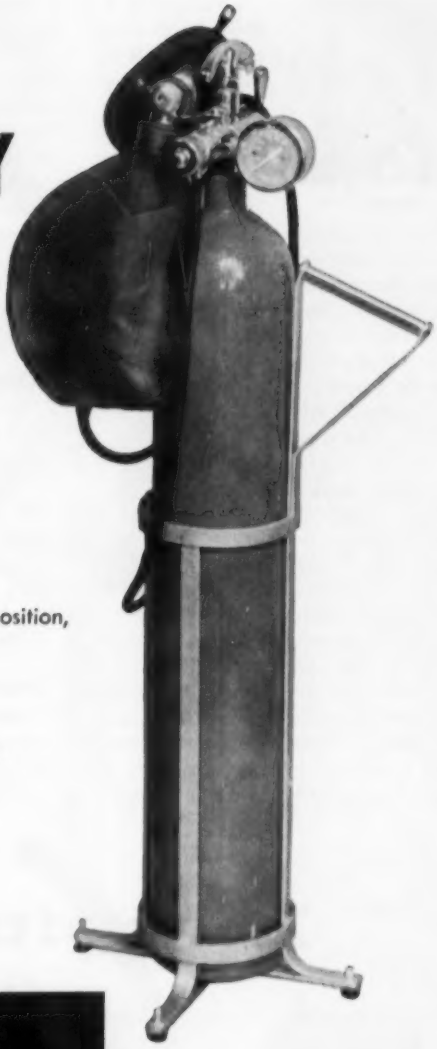

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Lawrence Dutel

Lawrence J. Dutel, who recently completed his administrative residency at University Hospital and Hillman Clinic, University of Alabama Medical Center, Birmingham, Ala., has been named assistant administrator there. Mr. Dutel received a master's degree in hospital administration from Northwestern University. A registered nurse, he will work with the clinical services of the hospital.

Edgar Furie

Edgar Philip Furie, who is currently taking graduate work at Northwestern University in hospital administration, has been appointed administrative resident at the Jewish Hospital Association, Cincinnati. Mr. Furie is a former member of the personnel staff of Michael Reese Hospital, Chicago.

Ray L. Wine, acting administrator of Deaconess Hospital, Freeport, Ill., has been named administrator there.

Sister Georgette Leduc, director of the school of nursing and assistant administrator of St. Vincent's Hospital, Toledo, Ohio, has been appointed administrator of St. Peter's Hospital, New Brunswick, N.J. She will replace **Sister Gilberte Baulne,** who has been appointed to the Holy Ghost Hospital, Cambridge, Mass. Prior to her appointment, Sister Leduc served as director of St. Peter's school of nursing.

William H. Cruse has accepted the position of administrator of Bella Vista Community Hospital, Los Angeles.

CORRECTION

In reporting the appointment of **Dr. Karl S. Klicka** as chief administrative officer of the Presbyterian-St. Luke's Hospital, Chicago, in the June issue of The MODERN HOSPITAL, he was incorrectly described as "medical director" instead of "director." In the same report, **Joseph P. Greer** should have been titled "assistant director" instead of "assistant administrator."

Department Heads

Mildred F. O'Donnell has resigned as executive housekeeper of Mount Auburn Hospital, Cambridge, Mass. Mrs. O'Donnell was graduated from Hartford Hospital Training School for Nurses, Hartford, Conn., and spent several years in supervisory positions in nursing before becoming an executive housekeeper. She served with Mount Auburn for 10 years. Mrs. O'Donnell set up an extension course in housekeeping at Boston University in 1951 and has served on the hospital housekeeping committee of the American Hospital Association. She is a member of the national board of the National Executive Housekeepers Association and was recently reappointed national educational chairman for hospitals.

Constance O'Brien

Constance Long O'Brien, coordinator of nursing education at City of Hope National Medical Center, Los Angeles, has been named director of nursing services there, succeeding **Ida McCardle. Mrs. O'Brien,** director of nursing services for the U.S. Public Health Service before joining the City of Hope staff, is a graduate of New York University and received a master's degree from Columbia University.

Helen Marr Jewett has resigned her duties as principal of the school of nursing at Tacoma General Hospital, Tacoma, Wash.

Mrs. Frankie J. Philpott, R.N., has been appointed director of nursing service of the Walker Memorial Sanitarium and Hospital, Avon Park, Fla. Mrs. Philpott was formerly associated with the Porter Sanitarium and Hospital, Denver.

Evelyn Dye, R.N., has been named director of nursing of South Florida Baptist Hospital, Plant City, Fla., succeeding **Minnie Lee West,** who resigned. At the same hospital, **Lannie Enfinger** has assumed the duties of head of the dietary department, replacing **Marietta Worthen.**

G. DeWitt Brown has been appointed controller of the Baptist Memorial Hospital, Jacksonville, Fla. Mr. Brown has been assistant administrator of the Central Baptist Hospital in Lexington, Ky., and administrator of Southeastern Kentucky Baptist Hospital in Corbin, Ky.

Florence Lynch is the new executive housekeeper at Beth Israel Hospital, Boston, succeeding **June Malone,** who resigned to assume a similar position at Muhlenberg Hospital, Plainfield, N.J. At the same time, it was an-

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nounced that **Louis B. Ely** has been named assistant administrative engineer of the hospital.

Ruth E. Benfield, formerly director of nurses at South Side Hospital, Pittsburgh, has been named director of nurses at Canonsburg General Hospital, Pittsburgh, succeeding **Elizabeth V. Harper.** Miss Benfield is a graduate of St. Luke's Hospital at Bethlehem, Pa., and obtained a bachelor's degree at Carnegie Institute of Technology.

Montez Dean

Montez M. Dean has been named personnel officer at East Orange General Hospital, East Orange, N.J. Miss Dean, who was formerly personnel assistant at Walter Kidde & Co., Belleville, N.J., is a graduate of Rutgers University, where she studied personnel management. Miss Dean's position is newly created by the 200 bed hospital.

Judith A. Hall, associated with Newton-Wellesley Hospital, Newton Lower Falls, Mass., has assumed the duties of chief pharmacist at Hartford Hospital, Hartford, Conn. A graduate of the Massachusetts College of Pharmacy, Miss Hall succeeds **John W. Webb,** who has accepted the position of associate in the pharmacy department at Massachusetts General Hospital, Boston.

Kenneth E. Squier has been named office manager at Vancouver Memorial Hospital, Vancouver, Wash., to succeed **Carl Ibach,** who has resigned.

E. G. McGrath

Edward G. McGrath has been appointed public relations director of the New England Deaconess Hospital, Boston. Mr. McGrath has been associated with the *Boston Post* for six years as feature writer, general assignment reporter, and copy editor.

R. A. Lorini

Ralph A. Lorini is the new controller of Roosevelt Hospital, New York. Mr. Lorini was formerly controller of the Protestant Council of Churches of the City of New York. He is a graduate of New York University's school of commerce, accounts and finance.

Gladys McWright has been named

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director of nursing service of Jones County Community Hospital, Laurel, Miss. Mrs. McWright succeeds **Evelyn Belknap,** who has resigned.


Col. B. J. Kotte

Col. Bernard J. Kotte is the new director of the Brooke Army Medical Center supply division, Fort Sam Houston, Tex. Col. Kotte was formerly executive officer of the supply division in the office of the surgeon general in Washington, D.C. He is a member of the Association of Military Surgeons and the American Pharmaceutical Association. He succeeds **Col. Everett W. Partin,** who is being assigned to 6th army headquarters, Presidio of San Francisco, where he will assume the duties of staff medical supply officer for the army surgeon.

Christian Lee has assumed the duties of purchasing agent at Norton Memorial Infirmary, Louisville, Ky. Prior to his appointment, Mr. Lee was purchasing agent for the Cleveland Hospital Council. **Joseph L. Keyes** succeeds him as purchasing agent for the council.


A. D. Haggerty

Arthur D. Haggerty has been appointed to the faculty of the school of nursing of St. John's Episcopal Hospital, Brooklyn, N.Y., and to the nursing committee there. Mr. Haggerty is a certified psychologist, who has worked in the fields of child psychology, therapy and adult guidance.

Paul F. Parker, formerly chief pharmacist of the University of Chicago clinics, is now director of the hospital section of the American Pharmaceutical Association and the American Society of Hospital Pharmacists. Mr. Parker succeeds **Don Francke,** chief pharmacist at the University of Michigan Hospital, Ann Arbor, who had directed the sections on a part-time basis.

Beatrice Phillips has been named director of the social service department at Beth Israel Hospital, Boston. Mrs. Phillips will succeed **Bess Dana.**

Jean Doty, R.N., formerly director of nursing service for Red Cross headquarters, Omaha, Neb., has been appointed to a similar post at North Platte Memorial Hospital, North Platte, Neb.

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Raymond Farrell, assistant accountant at St. Francis Hospital, Hartford, Conn., is the new chief accountant there.

Charles R. Carswell, supervisor of accounts at Newark Beth Israel Hospital, Newark, N.J., has assumed the duties of business office manager at the hospital.

Miscellaneous

Harry House, manager of the Pierce County Industrial Medical Bureau, Tacoma, Wash., retired June 15. **Laurence Evoy,** manager of Doctors' Hospital, Tacoma, succeeds Mr. House. **Dr. Homer Humiston,** Tacoma physician, was named medical director of the bureau.

Theodore Last has been appointed to the staff of the health division of United Community Services, Boston, where he will be associated with the Medical Care Regionalization Program recently announced by U.C.S. and supported by the U.S. Public Health Service.

Margaret Giffin has assumed the duties of the director of the department of hospital nursing, National League for Nursing, Inc., New York City.

Mary Jane Mordan has been appointed assistant professor of nursing in the school of nursing, University of Michigan. She received the degree of master of nursing from Yale University, where she completed the graduate program in mental health nursing.

John R. Chase, assistant controller at Rochester Hospital Service Corporation, Rochester, N.Y., has been named office manager there.

Deaths

Dr. Charles J. Kaufman, 59, head of the tuberculosis service at the Veterans Administration Hospital, Castle Point, N.Y., for the last 10 years, died recently. Dr. Kaufman was medical director of the National Jewish Hospital in Denver from 1936 to 1946. A former faculty member of the medical schools of Cornell University and the University of Colorado, Dr. Kaufman was a fellow of the New York Academy of Medicine.

Dr. Claire H. Carpenter, assistant director at the Northwestern Branch of Grace Hospital, Detroit, died June 27. He was formerly chief resident physician at Grace Hospital for 21 years.

J. H. Hargon, administrator of Leeds Hospital, Leeds, Ala., died recently.

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THE BOOK SHELF

THE ROCHESTER REGIONAL HOSPITAL COUNCIL. *By Leonard S. Rosenfeld, M.D., and Henry B. Makover, M.D. Cloth. Price* $3.50. *Pp* 204. *Published for the Commonwealth Fund by Harvard University Press, Cambridge, Mass.*, 1956.

Based on a study they conducted for the Institute of Administrative Medicine of Columbia University's School of Public Health, the authors present this report as a detailed evaluation of the program of the Rochester Regional Hospital Council, which was organized in 1946. The report includes descriptions and judgments concerning programs of shared professional services, education, personnel, purchasing, planning and other services. Hospital administrators and trustees in areas where cooperative efforts such as the Rochester Regional Council have not yet been undertaken will find here a valuable guide to the organization and operation of a regional service, including danger signs marking out areas where the value of cooperative effort is more apparent than real.

For example, the authors (both of whom are physicians) concluded that the program of clinical conferences for community hospital medical staffs, with visiting consultants, was not wholly successful. "There was general agreement among the consultants on the lack of opportunity for clinical discussion and the apathy of local medical staffs with regard to preparation and presentation of appropriate cases," the report said. "They suggested that topics are not always wisely chosen. Physicians at times request talks on certain aspects of medical practice because of deficiencies on the part of several of the staff members. However, at these talks those physicians who stand to benefit most often do not attend. . . . In about half the hospitals, physicians indicated that conferences were well attended and were of definite value in introducing new ideas and improving the interest and sense of responsibility among members of the medical staff. However, at other hospitals, physicians stated, as did some consultants, that the sessions were too didactic, and that there was limited participation by local physicians."

Other educational programs — for administrators, nurses and other hospital personnel — were judged more successful. "On the whole, there can be little doubt that the educational efforts of the council have been valuable," the authors stated. "They have helped to promote greater understanding among the various professional and nonprofessional groups, not only as to their own activities, but by providing greater insight into the problems and objectives of other groups and agencies."

The section of the report on group purchasing, especially, will interest hospital administrators who have heard this controversial subject discussed from all sides in recent years.

The purchasing program appears to have been moderately successful; following its inception in 1947 the volume of purchases grew to $229,000 in 1949 and to $408,000 in 1953. A study conducted by the council in 1950 showed that "savings realized by hospitals through joint purchasing ranged from 3 to 5 per cent in large hospitals and from 16 to 25 per cent in hospitals of 50 beds and under," it was reported. The average saving was reported to be about 10 per cent.

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ing in the purchasing program increased from 16 in 1947 to 24 in 1953. In 1949, 4.4 per cent of expenditures for supplies and equipment of participating hospitals was spent through the joint purchasing program. In 1953, this increased to 5.3 per cent. There is considerable variation in utilization of the service by member hospitals, according to the report. "In general, the smallest use of this service occurs in the hospitals with capacities of 300 beds and over," the report said.

In concluding the report, the authors list several "essential ingredients" necessary to development of a regional organization for health services. Among these are:

1. A cohesive area about a medical center, large enough to support a variety of specialized facilities and services to make the area self-sufficient for all but the most highly specialized services.

2. Recognition of the need for coordination and readiness to cooperate in providing for common needs among the various agencies and communities.

3. An administrative agency for coordinating specialized and local agencies, planning, organization and administration of regional services and to provide general leadership in meeting new problems.

In a recent speech, the president-elect of the American Hospital Association predicted that in years to come regional hospital councils would become more and more important to the individual community hospital. This report of the first eight years of one of the most successful of the regional councils provides strong supporting evidence that this will be the case.

THE HUNTERDON MEDICAL CENTER. *By Dr. Ray E. Trussell. Cambridge, Mass.: Harvard University Press.* 1956. *Pp.* 236. $3.75.

Those of us who have been theorizing on the subject of social medicine and struggling to do something about it here and there over the years can now point to this volume as evidence that certain good things, which have been considered difficult to do, can be done if there is a communal will to do it. It is one of the merits of this very readable volume that it proves conclusively what many of us have been saying over the years—you can get the wherewithal for good causes and you can recruit a good staff if the leadership is there and the functional program and corresponding structural layout are sufficiently attractive.

Luck had little to do with the success of the Hunterdon project. It started when a group of communally minded citizens in a rural New Jersey area, serving under dedicated leadership, engaged the services of the late Dr. E. H. Lewinski-Corwin to prepare a functional blueprint of modern medical care for their consideration. "Group dynamics" followed with its democratic best and a director was engaged who added his own considerable talents to the sum total of available energy and ability to see the project through.

The best medical care for all elements of this rural population, without regard to any consideration other than their own individual needs at the time, all of it centered in a comprehensive general hospital and radiating from it, was provided along cooperative lines which excite admiration at every step.

They have still to combine the health department with the hospital, but much integration has already been achieved through functional collaboration. They have still to elaborate a sound plan of prepaid health insurance, but the ingredients of progress in such directions are very much in practical evidence. This book is frank on such subjects and one comes away with the impression that the first few years have achieved mightily with a minimum of social or medical controversy. "Acute" and "chronic," inpatient and outpatient, intramural and extramural, private and "ward" are almost indistinguishable here. The full-time principle for specialists prevails, to the great advantage of the family physician as well as of his patients. Medical research is encouraged and so is medical education, under the helpful assistance and unusual insight on the part of a great medical school situated in a neighboring state.

One reads these pages with a certain amount of envy as well as pride. Many exceptions to administrative rules, high consultation rates, high rates of postmortem examinations, low negative operative tissue rates, minimal opportunities for malpractice, excellent records and, above all, continuity of care—you will find them all here.

This is the kind of book that stirs you from beginning to end. It is well written and takes every modern modality of medical care into consideration.—E. M. BLUESTONE, M.D.

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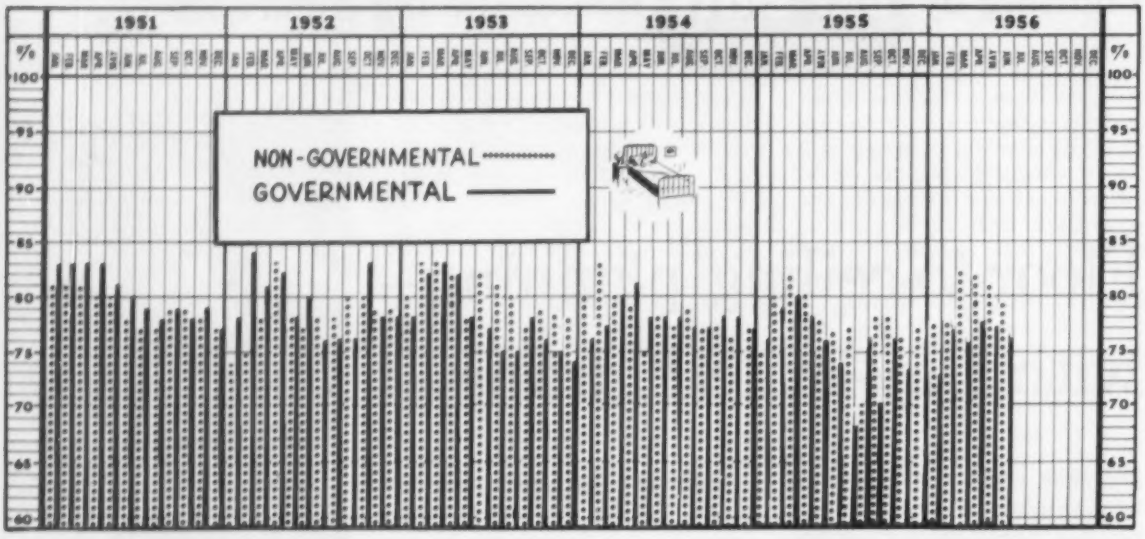

Voluntary hospitals reporting occupancy for the month of June indicated they were filled to 79.4 per cent of capacity. Governmental hospitals reported occupancy at 76.2 per cent of capacity. June 1955 reports to the Occupancy Chart were 75.7 per cent and 70 per cent, respectively.

From June 11 through July 9, hospital construction totaled $75,160,370, bringing the year's building total thus far to $451,868,631. For the comparable construction period last year, building amounted to $67,513,900 and brought 1955's hospital building total to $364,398,979. Of the 94 current projects, 22 are hospitals, 58 are additions and nine are alteration projects.

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ANESTHETIST—Male M.D.; available immediately; many years' experience all phases anesthesia; salary on percentage. Apply MW 120, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

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ADMINISTRATOR—Professional nurse; B.S. in Nursing; M.P.H., Hospital Administration; one year, administrative resident and three years, assistant administrator; 400-bed general hospital.

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COMPTROLLER—B.S., Business Administration; Major, Accounting; eleven years, comptroller, large teaching hospital.

PATHOLOGIST—Diplomate, Pathologic Anatomy; Clinical Pathology; three years' full time teaching seven years, director of pathology, 300-bed general hospital; FACP.

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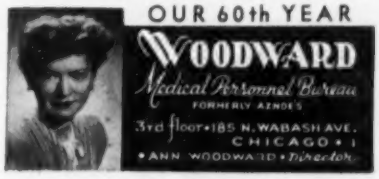

ADMINISTRATOR—(b) B.S., M.H.A.; past 2 years, reorganization project, general hospital, 160-beds; completed successfully; seeks permanent post, 100-beds up, preferably metropolitan area, any locality; references unite in excellent commendations; Nominee ACHA.

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RADIOLOGIST—(i) Woman; southerner; Diplomate, roentgenology; 4 years, private practice, radiology; licensed, and prefers Texas; early 40's.

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(Continued on page 206)

INTERSTATE—*Continued*

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ANESTHETIST—Nurse A.A.N.A.; 125-bed hospital; salary $500 per month; operating suite completely air conditioned. Apply MO 145, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ANESTHETIST—Nurse; for obstetrics or surgery, salary open, three weeks vacation the first year, 12 days sick leave per year, accumulative. Apply to Personnel Director, Methodist Hospital, 1600 West 6th Avenue, Gary, Indiana.

ANESTHETISTS — Nurse for 155-bed modern general hospital; air conditioned work areas; good personnel program; remuneration $5,000-$6,500. Call or write Administrator Midland Hospital, Midland, Michigan.

ANESTHETIST—Position open in 200-bed hospital in Minot, North Dakota; salary according to qualifications; not less than $400.00 per month plus maintenance; 4 weeks vacation, 40 hour week. For further information write to Trinity Hospital, Minot, North Dakota.

ANESTHETISTS—Nurse; two required; immediately for 250-bed general hospital; modern, accredited, standard hospital personnel policies, fine community adjacent to Cleveland; salary open; full maintenance available. Apply Miss Ines Ealy, R.N., Anesthesia Department, The Elyria Memorial Hospital, Elyria, Ohio.

ANESTHETIST—Nurse; 36-bed rural hospital, F.A.C.S. surgeon; open salary plus bonus plan; if you can be happy in a friendly rural hospital with excellent facilities where your ability will be appreciated. Apply Administrator, Mooreland Hospital, Mooreland, Oklahoma.

ANESTHETISTS—Nurse; modern 400-bed hospital; staff of 5 nurse anesthetists and 1 anesthesiologist; salary up to $400 and other benefits; For particulars contact Vincent A. Kehm, M.D., Chief Anesthesia, York Hospital, York, Pennsylvania.

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DIETITIANS—Therapeutic dietitians; Barnes Hospital, large teaching hospital; 3 units affiliated with Washington University School of Medicine; beginning salary $270 month; social security. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN—Chief; 450-bed voluntary general hospital, large diabetic service, has immediate opening for experienced chief dietitian; duties include supervising dietary department; remodeling department in near future; salary open. Address letters of application to The Administrator, Good Samaritan Hospital, Portland, Oregon.

DIRECTOR OF DIETETICS—To administer entire dietary department for 925-bed teaching hospital system; salary open. Contact L. S. Hartford, Assistant Administrator, Plant and Services, University of Texas Medical Branch, Galveston, Texas.

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DIRECTOR OF NURSES—Very modern hospital, popular resort area, excellent opportunity, full responsibility; supervisory experience required; salary dependent on qualifications, about $5,000; full interview expense by arrangement. Contact Administrator, Schoolcraft Memorial Hospital, Manistique, Michigan.

DIRECTOR OF NURSING SERVICE AND EDUCATION—Experienced; general hospital, 125-beds, 45 students, near Adirondack Mountains. Apply D. J. Thomas, Executive Director, Nathan Littauer Hospital, Gloversville, New York.

DIRECTOR OF NURSING—For a 2700-bed state psychiatric hospital, beautiful location; director is responsible for the affiliate school and for nursing service; Degree in nursing education plus administrative and teaching experience required; retirement plan, 40-hour week. For further information write Superintendent. Danville State Hospital, Danville, Pennsylvania.

DIRECTOR OF NURSING SERVICE—Immediately for 276-bed general hospital; postgraduate course in administration favored, experience preferred. Apply Administrator, St. Paul's Hospital, Saskatoon, Saskatchewan.

EDUCATIONAL DIRECTOR FOR SCHOOL OF NURSING—Experience in nursing service and a B.S. Degree in Nursing Education minimum requirements, Master's Degree in Nursing or in general education preferred; salary open; excellent opportunity for a desirable faculty experience. Apply to Personnel Director, Methodist Hospital, 1600 West 6th Avenue, Gary, Indiana.

EXECUTIVE—Experienced; to advise in construction of 65-bed hospital in central Missouri this fall; assume administration when completed. Apply to Jefferson City Memorial Hospital Association, Jefferson City, Missouri.

INSTRUCTOR and ASSISTANT INSTRUCTOR—Tuberculosis nursing; 223-bed sanatorium, new facilities; to set up a student affiliation program in tuberculosis nursing with emphasis on the public health aspect; Master's degree preferred for instructor; Baccalaureate degree required for assistant; salary commensurate with educational background and teaching experience; 40 hour week, 7 paid holidays, liberal vacation, sick leave, social security. Apply W. C. Anderson, Executive Director, Emily P. Bissell Sanatorium, 3000 Newport Gap Pike, Wilmington 8, Delaware.

INSTRUCTOR—Medical clinical; opening available July '56; liberal personnel policies; 40 hour week, 28 days vacation, 8 paid holidays, 18 miles from New York City; live in if desired; new ultra-modern 350-bed hospital will be completed in April 1957. Apply Director of Nurses, Clara Maass Memorial Hospital, 12th Avenue & Newton Street, Newark, New Jersey.

INSTRUCTOR—Nursing arts; opening available August '56; salary commensurate with education and experience, 40 hour week, 28 days vacation, 8 paid holidays; 18 miles from New York City; live in if desired; new ultra-modern 350-bed hospital will be completed in April 1957. Apply Director of Nurses, Clara Maass Memorial Hospital, 12th Avenue & Newton Street, Newark, New Jersey.

INSTRUCTOR—Clinical; medical and surgical nursing, fully accredited school attached to 400-bed, general hospital, 25 minutes from Times Square, staff or head nurse experience, B.S. preferred; liberal personnel policies. Apply Personnel Director, The Brooklyn Hospital, 121 DeKalb Avenue, Brooklyn 1, New York.

INSTRUCTOR—Clinical; medical and surgical nursing; new facilities; diploma program; B.S. in nursing education required; salary open. Apply Director of Nursing, Arnot Ogden Memorial Hospital, Elmira, N.Y.

INSTRUCTOR FOR NURSES' AIDES—General hospital treating men, women and children; 128 adult and pediatric beds plus 24 bassinets; 40 hour week; salary open. Apply Director, Woman's Hospital, 1940 East 101st Street, Cleveland 6, Ohio.

LAUNDRY MANAGER—For 300-bed teaching hospital in Columbus, Ohio; former laundry management preferred but will consider applicant who has served as an assistant in recognized hospital laundry procedure; ability to manage laundry personnel essential. Apply MO 147, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

LIBRARIAN—Medical record; to assume charge medical record department of 100-bed fully approved general hospital; salary open. Apply Administrator, Beebe Hospital, Lewes, Delaware.

LIBRARIAN—Registered medical record; 250-bed hospital located on bank of the Hudson; unit system and standard nomenclature; competent record room staff; air conditioned office, 40 hour week, 1 month vacation and liberal sick benefits; substantial salary. Apply, Vassar Brothers Hospital, Poughkeepsie, New York.

LIBRARIAN—Superior opportunity for RRL to head medical records department in modern 650-bed general hospital; outstanding medical staff cooperation; excellent salary commensurate with experience; progressive personnel policies including social security and hospital pension plan. Contact Director, Miami Valley Hospital, Dayton 9, Ohio.

(Continued on page 208)

LIBRARIAN—Medical record; registered; to assume charge of record room; 135-bed general hospital; 40 hours; salary open. Contact Miss G. A. Cooper, Woman's Hospital, Cleveland 6, Ohio.

MISCELLANEOUS—1-Chief Instructor in charge of the class program of the educational program; 1-Science Instructor to teach microbiology, anatomy and physiology; 1-Clinical Instructor to teach medical and surgical nursing; degree helpful; 400-bed general volunteer hospital; 40 hour week, pension-group insurance plan; 1 month vacation; employee benefit plan; accumulated sick leave, approved School of Nursing; intern-resident training program; interested to arrange comparable salary. Apply Personnel Director, Christ Hospital, 2139 Auburn Avenue, Cincinnati 19, Ohio.

MISCELLANEOUS—(1) Executive Housekeeper; salary open; (2) X-Ray Technician; female; salary based upon merit; 200-bed hospital. Apply Nell Robinson, Superintendent, East Liverpool City Hospital, East Liverpool, Ohio.

MISCELLANEOUS—Science Instructor (1) for August 1; Clinical Instructor (1) good teaching facilities 1 class of approximately 30 students yearly; good personnel policies; near enough to Rocky Mountain National Parks for days off. Apply stating qualifications and salary expected to Director of Nursing, St. Michael's Hospital, Lethbridge, Alberta.

NURSES—Interested in dynamic tuberculosis program in suburbs of Nation's capital; all civil service benefits; opportunities for academic and professional growth arranged. Write Director of Nursing, Glenn Dale Hospital, Glenn Dale, Maryland.

NURSES—Specializing in tuberculosis and chest diseases; 600-bed hospital, located 30 miles from Springfield, Missouri; developing pediatrics department, in-service and affiliation program; merit system benefits; full maintenance and laundry minimum rate; staff nurse, $250-$335. Write Director of Nursing, Missouri State Sanatorium, Mt. Vernon, Missouri.

NURSES—General duty; three positions open in surgery; beginning salary $270 plus time and one half for overtime; good personnel policies; surgery has recently been renovated; 109-bed hospital; all graduate staff; accommodations for rooms if desired. Apply MO 143, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

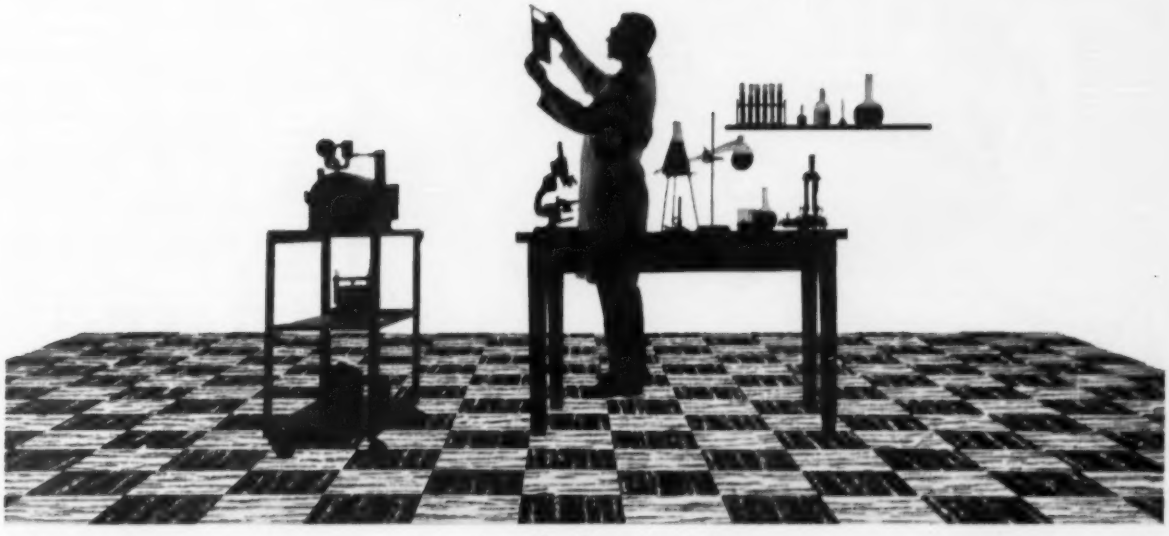
NURSES—General duty; for 54-bed general hospital; beginning salary $300 per month on 3-11 and 11-7; 2 weeks paid vacation a year, 44 hour week. Apply Director of Nurses, Southeastern Kentucky Baptist Hospital, Corbin, Kentucky.

NURSES—General duty and operating room; for 210-bed teaching hospital, located 35 miles from New York City; salary $260-290 per month, 5 days 40 hour week; $20 extra 3-11 and $15 extra for 11-7; operating room nurses $10 extra per month; liberal personnel policies including 3 weeks vacation, 12 days sick leave, social security; pleasant living facilities provided if desired. Write or apply Director of Nursing, White Plains Hospital, White Plains, New York.

NURSES—Graduate; for 64-bed private hospital and clinic, near San Francisco; close proximity to vacation areas. Write Director of Nurses, Woodland Clinic Hospital, Woodland, California.

NURSES—Graduate; permanent positions available on all shifts. Inquire Director of Nursing Service, St. Thomas Hospital, Akron, Ohio.

from the **entrance hall**



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POSITIONS OPEN

NURSES—Graduate; two; if interested contact Medical Director, Florida State Hospital, Arcadia, Florida.

NURSES—Graduate professional; openings on all services, 600-bed teaching and research hospital; opportunities for continued study; exceptional personnel policies; beginning salary $260.91 per month with annual increments. For further information write Associate Director Nursing Service, University Hospital, Baltimore 1, Maryland.

NURSES—Operating room; male and female; immediate appointments for staff and head nurses in medical center; all types of special surgery; 30 days vacation, 8 paid holidays; staff nurses—$320 to $335 per month; head nurses $335 to $375; evening duty differential $40; night duty $30. Write to Associate Director, Nursing Service, Michael Reese Hospital Medical Center, Chicago 16, Illinois.

NURSES—Operating room; for teaching hospital within walking distance of teachers college; salaries and personnel policies comparable to other hospitals in area. Write Director of Nursing, Box P, St. Luke's Hospital, New York 25, N.Y.

NURSE—Operating room; for modern air-conditioned, two room suite, in 52-bed general hospital; 12 days sick leave, 2 weeks vacation annually, paid holidays, annual bonus, 40-hour week; salary open. Apply Director of Nurses, Parkview Hospital, 1920 Parkwood Avenue, Toledo 2, Ohio.

NURSES—Psychiatric; for supervising psychiatric buildings and attendants; mature, experienced; $3,000 per year, board, room and laundry available at $480 per year; social security and pension. Send full information to Director of Nurses, Brattleboro Retreat, Brattleboro, Vermont.

NURSE—Registered; interested in teaching practical nursing; opportunities to develop own program; school not approved at present; desire individual capable of developing program which will meet State approval; small town located in south east Pennsylvania. Apply MO 144, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

NURSE—Registered; 145-bed geriatric institution Philadelphia suburban area; excellent opportunity, good salary, state experience. Apply MO 148, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

NURSES—Registered; positions available for R.N.'s under age 50; general duty;—$330.00 per month; head nurse—$345.00 to $360.00 per month; evening and night differentials, retirement plan, sick leave benefits, 11 holidays, 3 weeks vacation, modern nurses residences, state eligibility for California registration and submit photo to Director of Nurses, Tulare-Kings Counties Hospital, Springville, California.

NURSES—Registered; for modern psychiatric hospital in Greens Farms, Connecticut; 1 hour from New York; Hall-Brooke nurses have 8-hour duty, optional 5 or 6 day week, nicely furnished private rooms; excellent salary, 7 paid holidays annually, or equivalent; sick leave; vacation, minimum 2 weeks, maximum 4 weeks dependent on length of service; profit-sharing plan; psychiatric experience not necessary; registered or eligible in State of Connecticut. Apply Mary R. Walsh, R.N., Directress of Nursing, Hall-Brooke, Box 31, Greens Farms, Connecticut. Tel. Westport—Capital 7-5105.

NURSES—registered; Massachusetts General Hospital, Boston, Massachusetts; excellent clinical facilities, opportunity for advancement and attendance at local colleges; liberal personnel policies. Apply Personnel Department A-10 for further details.

NURSES—Registered; for all shifts; 30-bed hospital, moving into new 50-bed hospital soon; starting salary $300 per month, 44-hour week, other benefits. Carlsbad Memorial Hospital, Carlsbad, New Mexico.

NURSES—Registered operating room; staff positions in 400-bed, teaching hospital, 25 minutes from Times Square; salary $270-$290 per month; 5 days, 40 hour week; 4 weeks vacation; 21 sick days, 7 holidays. Apply Personnel Officer, The Brooklyn Hospital, 121 DeKalb Avenue, Brooklyn 1, New York.

NURSES—Registered; there are positions open for staff and assistant head nurses in the new 277-bed University of Oregon Medical School Hospital in Portland, Oregon; arrangements may be made for attending classes on campus which lead to baccalaureate or masters degrees in nursing. For full information write to Director of Nursing Service.

NURSES—Registered; for general staff duty in 53-bed general hospital, air conditioned; located 25 miles from Texas coast; population 50,000; 44 hour week, 2 weeks paid vacation, 3 weeks after 5 years, 6 paid holidays, liberal personnel policies; salary open. Write or call, Mrs. Hazel Woods Riddle, R.N. Director of Nurses, DeTar Memorial Hospital, Victoria, Texas.

NURSES—Staff; for new expanding hospital on Florida's west coast; salaries and personnel policies compare favorably with those in this area: 40-hour week, 4 weeks vacation, no shift rotation; Florida registration required. Apply Supervisor Nursing Service, Manatee Memorial Hospital, Bradenton, Florida.

NURSES—Staff; for 78-bed hospital, provisionally approved by JCAH; 5½-day week; opening for all rotating shifts; particularly need applicants for director of nurses and operating room supervisor; bonus for, evening and night duty, sick leave, vacation, holidays, social security benefits; opportunities for sports and entertainment, one of the most scenic areas of southeastern United States; if interested write E. L. Crozier, Administrator, Somerset City Hospital, Somerset, Kentucky, giving training and working experience in first letter.

NURSES—General staff; for T.B. sanatorium and infirmary for older persons near Pontiac, Michigan, in the Detroit metropolitan area; salary $3861 to $4173 per year; liberal sick leave and retirement benefits including social security; must be eligible for Michigan registration. Apply Personnel Office, Oakland County Office Building, 1 Lafayette St., Pontiac 15, Michigan.

NURSES—Staff; for JCAH fully accredited 300-bed general non-sectarian hospital; near shore resorts and New York; opportunities all clinical fields; regular increments, 4 weeks vacation, 40 hour week; inservice program, college extension courses; supervised day nursery for your children; salary range—days $260-$290 per month, evenings, nights $280-$310 per month. Apply Director of Nurses, Saint Barnabas Hospital, 685 High Street, Newark 2, New Jersey.

(Continued on page 210)

NURSES—Staff Grade 1, B. C. Civil Service, Provincial Mental Hospital, Essondale; required for permanent positions and summer relief work; salary $239, rising to $271, per month; must be a registered nurse currently registered in B. C. or eligible for registration in the Province; preferably some experience in general nursing; applicants must be British Subjects. For further information and application forms apply Personnel Officer, Civil Service Commission, Essondale, B. C. Phone LA 1-1911.

PHARMACIST—Hospital; wanted for organization and management of pharmacy in 200-bed hospital; women applicants preferred; information given on application. Apply to Miss Nell Robinson, Superintendent, The East Liverpool City Hospital, East Liverpool, Ohio.

SUPERINTENDENT OF NURSES—150-bed general hospital; fully approved by Joint Commission on Accreditation; metropolitan area, northeast Ohio; suitable experience required no training school; salary open. Apply MO 133, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

SUPERVISOR—Obstetric; department of 51 beds, 60 bassinets in a 350-bed hospital; school of nursing with enrollment of 130 students; no teaching responsibilities; B.S. degree preferred, not essential if experienced or with supplementary preparation; 40-hour week, salary commensurate with preparation and experience; complete maintenance available at $30 per month. Apply Director of Nursing, Lutheran Hospital, 2639 Miami St., St. Louis 18, Missouri.

SUPERVISOR—Obstetrics; post graduate work in obstetrics and supervisory experience required; immediate opening; modern and up-to-date department; social security and excellent personnel benefits. Apply Director of Personnel, White Cross Hospital, 700 North Park Street, Columbus 8, Ohio.

SUPERVISOR—Operating room; modern 400-bed hospital; well qualified person needed; salary commensurate with experience; liberal personnel policies. Apply Superintendent of Nurses, York Hospital, York, Pennsylvania.

TECHNICIAN—General laboratory; male or female. Apply MO 135, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

TECHNICIAN—Laboratory; 125-bed hospital; excellent positions open for two clinical laboratory technicians who will qualify for the California Board; salary open; one month's vacation with pay, transportation expenses reimbursed if satisfactory. Communicate San Antonio Community Hospital, Upland, California.

TECHNICIAN—Laboratory; eligible for California license, for 75-bed hospital; very desirable location on Monterey Bay; generous personnel policies; salary open. Contact Laboratory Director, Watsonville Community Hospital, Watsonville, California.

TECHNOLOGIST—Clinical laboratory; male or female; applicants holding California license for laboratory technician given preference; paid call duty, 40 hour week; starting salary up to $315.00 for qualified unlicensed personnel; up to $350.00 for licensed personnel; fully approved 130-bed JCAH hospital operated in conjunction with large clinic. Apply A. G. Turner, Administrator, Kaiser Foundation Hospital, 9961 Sierra Avenue, Fontana, California.

TECHNOLOGIST—Laboratory; for general laboratory work in modern 150-bed hospital in Central Washington; registered ASCP technologist desired. For details write Pathologist, Yakima Valley Memorial Hospital, Yakima, Washington.

classified advertising

POSITIONS OPEN

ADMINISTRATORS — (a) Medical; 125-bed hospital increasing to 200-beds; mental deficient children & adults; psychiatric experience not required; lovely 7 room furnished home, not on hospital grounds, full family maintenance plus $10,000; delightful warm, dry climate year-round, near large university city. (b) Several units, 400-beds; attractive location; California. (c) Medical or non-medical; coordinator of medical education; new post; general, voluntary hospital large size; midwest. (d) Medical; 3 units, 300-beds; $12,000; if qualified also as county physician, $15,000; Westcoast. (e) General, voluntary hospital large size; teaching program; San Francisco area. (f) Voluntary, general hospital, 160-beds; midwest. (g) New, ultra-modern, general hospital 140-beds; good organizer required; east. (h) Hospital & Home, 125-beds; expansion program; should be Jewish; good salary, full family maintenance, 3 bedroom home; very desirable city. (i) To be erected; 100-beds; Eastern seaboard. (j) 100-bed JCAH hospital; midsouth. (k) Just licensed; 80-beds; large city; $10,000; bonus; California. (l) 75-beds Rio Grande Valley; Texas. (m) New 60-bed hospital opening early 1957; employ now to grow with organization; on ocean; California. (n) General, corporation 50-bed hospital; Ozark area, Missouri. (o) Voluntary general 45-bed hospital; lovely college town; Iowa.

ADMINISTRATORS—ASSISTANTS; (p) Teaching hospital 800-beds; east. (q) Teaching hospital 800-beds; $7500; university city; midwest. (r) General hospital 500-beds; Ohio. (s) 250-beds; New England. (t) 300-beds; Michigan. (u) 225-beds; Wisconsin. (v) 300-beds; California.

ADMINISTRATIVE ASSISTANTS — (w) Full charge emergency ward; 900-bed, medical school affiliated hospital; university city; east. (x) General, voluntary hospital 600-beds; to $8000; university city; Midwest. (y) Two affiliated general hospitals, 550-beds; large city; West.

ADMINISTRATORS — Women; (a) R.N. or non-medical; general hospital 100-beds; to $600; progressive town 20,000; southwest. (b) R.N., 20-bed general hospital; small town near well known university center; midwest. (c) R.N. or non-medical; fairly new general hospital 50-beds; resort and college community; Florida.

ANESTHETISTS—(a) Approved general hospital 250-beds; $500, maintenance at nominal cost; large southwestern city. (b) Voluntary general hospital 25-beds; new building now under construction; lake resort community, New England. (c) Two required; approved 100-bed general hospital; to $500; resort, outdoor sport area; Pacific Northwest.

DIETITIANS—(a) Administrative; new, fully approved general hospital 230-beds; well known university medical center; east; $5000. (b) Voluntary general hospital 100-beds; progressive California community. (c) Chief; full administrative responsibility, excellent departmental staff; 350-bed general hospital; $5000 up; large city; east.

WOODWARD—*Continued*

DIRECTOR OF NURSES—(a)Challenging opportunity to build departments of nursing service and education in well-established, large general hospital; fully approved school, enrollment nearly 200 students; large university city, midwest. (b) Nursing service only; 200-bed general hospital; to $450; winter resort, Florida. (c) Nursing service only; 100-bed tuberculosis hospital, expanding to 250-beds in two years; $450 or better; California. (d) Nursing service and education; voluntary general hospital 200-beds; to $6000; large city near well known university medical center; midwest.

EDUCATIONAL DIRECTORS—(a) Director, new practical nursing education program to be inaugurated by well known Eastern junior college; full administrative responsibility for implementing program; to $7200, depending on academic preparation. (b) Approved school, 175 students now enrolled; very large general hospital, south. (c) Associate, excellent opportunity for advancement; 300-bed general hospital; San Francisco Bay area. (d) By very large general hospital; challenging opportunity to build school; to about $7,000; fairly large eastern city.

EXECUTIVE HOUSEKEEPERS—(a) Reorganize and direct departmental staff of about 40; fully approved, modern 250-bed general hospital in college city 100,000; mideast. (b) Fully approved general hospital 300-beds; progressive cultural, recreation center; Pacific Northwest. (c) Newly opened 250-bed general hospital; laundry and linen rooms included in responsibilities; lovely college city 100,000; soutneast.

ADMINISTRATORS — (a) Medical; 400-bed general hospital; medical school city, midwest. (b) Medical director and assistant medical director; county hospital; duties: direct hospital and clinical program; $900 & $750, homes, utilities; California. (c) Executive director; regional association, national health group; New England. (d) New 350-bed general hospital nearing completion; university city, midwest. (e) Voluntary general hospital, 300-beds relatively new; college town, south. (f) General 150-bed hospital recently opened; suburb, New York City; capable organizer required. (g) New general 60-bed hospital; planning stage; California. (h) Executive secretary; state hospital association; $7000-$10,000. (i) Assistant; 460-bed general hospital affiliated medical school; $6000-$8000, maximum of $10,000; midwest. (j) Assistant; new general hospital; university affiliation; 200-beds expanding to 450; teaching center, south. (k) Assistant; pediatric hospital, 250-beds, unit, university group; Master's in Hospital Administration, accounting experienced desired; $6000-$9000; East.—MH8-1

ANESTHETISTS—(a) Well renowned 30-man clinic; large university city; noted health resort, southwest; $6000. (b) Staff; ultra modern surgical suite; 250-bed hospital near university center, Long Island; $5500. (c) Free lance, salary or percentage; small new hospital; beautiful mountain area; southeast. (d) Large Pacific Island hospital; $5400; excellent personnel policies, retirement. (e) Small hospital; averages 46 anesthetics month; wealthy Iowa location; $7200. (f) Two; new hospital; Alaska; $525-$625. MH8-2

(Continued on page 212)

MEDICAL BUREAU—*Continued*

DIETITIANS—(a) Administrative; opportunity direct department, large general hospital; excellent Southwestern location; start $6000. (b) Chief; 350-bed hospital; Eastern seaport, resort area; $5700. MH8-3

DIRECTORS OF NURSING—(a) Director service and education; 500-bed well organized hospital; accredited school; adequate staff; beautiful Capitol City; east; $7000, maintenance. (b) Assistant director, nursing service; excellent opportunity for administrative responsibility; 250-bed hospital; $450, suite, laundry; on Long Island Sound. (c) Associate director nursing education; large general hospital; San Francisco Bay area; excellent opportunity (d) Director, nursing; 140-bed hospital in building program to 275; fine educational, cultural facilities; near progressive midwestern city; $5000-$6000. (e) Director, nursing; large general hospital; leading industrial city, good location; $6100-$7600; West Coast. MH8-4

EXECUTIVE HOUSEKEEPER—400-bed hospital; university affiliated; new building program; established new systems; manage, supervise; excellent opportunity; midwest. MH8-5

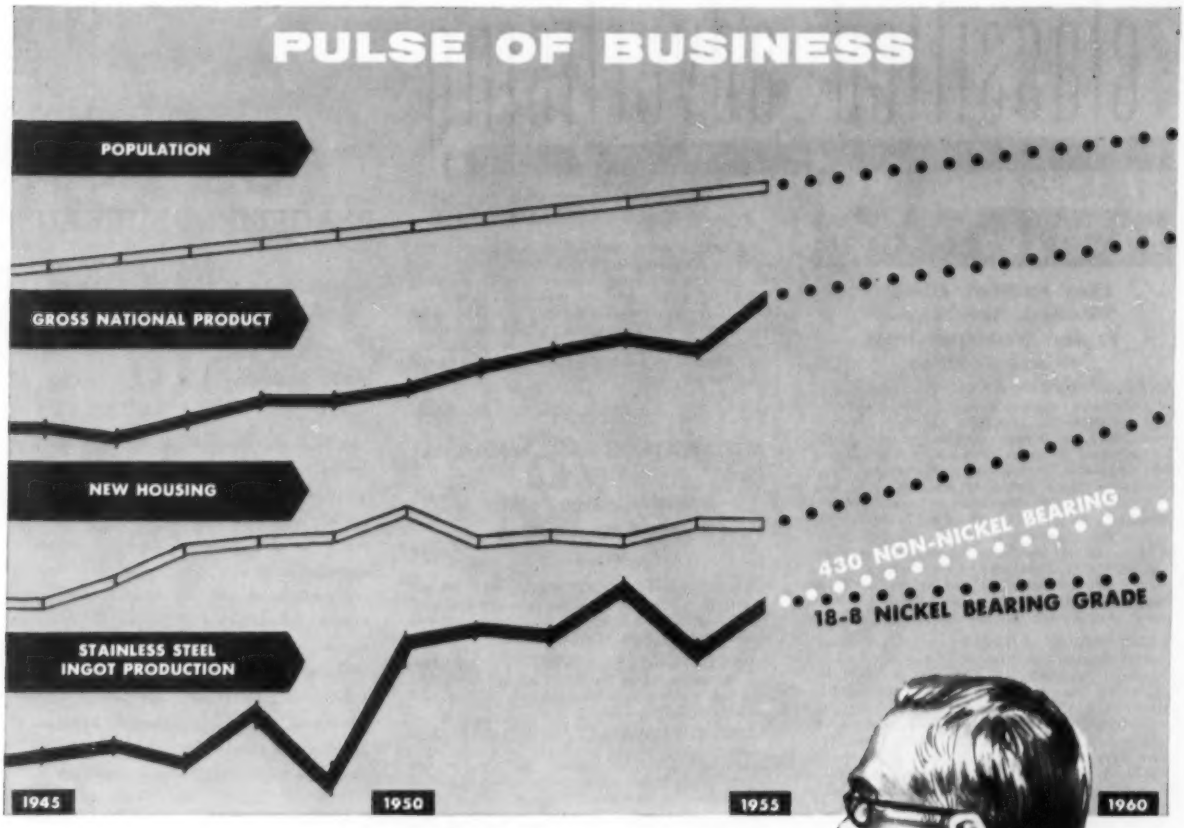
EXECUTIVE PERSONNEL — (a) Executive secretary, state nurses' association; professional nurse, academic degree, business experience required. (b) Accountant; supervisory position; 500-bed general hospital; large city, midwest. (c) Credit manager; 625-bed general hospital; expansion program to 1200; college town, south. (d) Personnel director; qualified to set up department for 800 employes; 400-bed hospital; larger hospital to be built; affiliated medical school; midwest. (e) Puchasing director; voluntary general hospital, 450-beds; California. (f) Public relations director; hospital association. (g) Food Production manager; interested in methods improvement; complete control department functions; 350-bed hospital; midwest. (h) Food service manager; traveling consultant to state institutions, southwest. MH8-6

FACULTY POSTS—(a) Director, education; 800-bed hospital; organize, administer newly renovated school; recognized eastern city; to $7000. (b) Medical-Surgical; psychiatric, clinical instructors; newly established university school of nursing; academic or calendar year; metropolitan area, leading midwestern city; to $5800. (c) Obstetric clinical instructor; 40-bed, segregated units; large internationally recognized hospital; interesting cosmopolitan city, outside United States; to $5500. (d) Assistant or associate professor; obstetrics, pediatrics, nursing arts; school of nursing, well known medical college; to $6000; historical southern city. MH8-7

RECORD LIBRARIANS—(a) Direct active, efficient department of 25; 900-bed general hospital; new, modern facilities; air-conditioned; ocean resort city. (b) Chief; 600-bed university hospital; principal teaching unit for medical college; key city, east; $5500. (c) Chief, qualified, establish medical records training school; 250-bed hospital; college town, southwest. MH8-8

STUDENT HEALTH — College preparatory school; 10-month year; university city, southwest. MH8-9

SUPERVISORS—(a) Operating room; 350-bed general hospital; commuting distance Chicago; to $6000. (b) Pediatric; progressive 300-bed hospital; large industrial city near prominent midwestern summer resort; $5000. (c) In-Service; 200-bed hospital; Florida coast resort city; to $400. (d) Medical supervisor; new 225-bed hospital affiliated university; foreign city. MH8-10



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POSITIONS OPEN

SHAY MEDICAL AGENCY
Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

EXECUTIVE PERSONNEL—(a) Comptroller; middle west; 400-bed hospital. (b) Personnel and community relations director; middle west; man or woman; 300-bed hospital; will be increased to about 400-beds in near future; 700 employees at present. (c) Personnel and public relations director; middle west; 400-bed hospital. (d) Purchasing agent; 200-bed hospital soon to be increased to 400-beds; top salary for experienced person. (e) Assistant administrator; middle east; 600-bed hospital; to $8000. (f) Assistant administrator; middle west; 500-bed hospital; prefer an M.S. in hospital administration. (g) Business Manager; Northwest; 100-bed hospital; to $7000.

DIRECTOR OF NURSES—(a) West Coast; Administrator and director of nurses of 50-bed hospital; hospital new, modern in every respect. (b) East; 150-bed hospital; prefer B.S. degree but will consider without if have good experience. (c) Southeast; winter resort area; 225-bed hospital; $6000. (d) Middle west; 75-bed hospital in city of 20,000; B.S. degree required; to $7200. (e) Middle west; 500-bed hospital; B.S. degree and good experience in nursing service administration; to $8000. (f) South; 150-bed hospital in beautiful small southern town close to several large cities; $6000 to $7200. (g) Assistant superintendent of nursing service; university hospital; position will carry regent appointment; resort area; $6000 to $6500. (h) East; 350-bed hospital; M.S. degree; experienced as director or assistant director of hospital with school of nursing; $7000 plus full maintenance.

DIETITIANS—(a) Chief; California; 250-bed hospital; 50 employees in department; $6000 to start. (b) Chief therapeutic; teaching hospital; A.D.A.; supervision and in-service training for 5 staff dietitians and 50 pantry maids; plan all therapeutic diets; $4000 minimum to start. (c) Therapeutic; complete charge of therapeutic diet Kitchen which is new and modern in every respect; 200-bed hospital; $4800. (d) Therapeutic; middle west; 100-bed hospital in college town; $385 to $425. (e) South; supervision of general diets, special diets and employees cafeteria; 35 employes in department; 200-bed hospital in city of 35,000; $4800 minimum. (e) Chief; south; 300-bed hospital; do all purchasing for dietary department, no teaching; $5000 to start—guaranteed increments; 1-2 and 3 years. (f) Chief; middle west; 200-bed hospital in college town; $6000. (g) Assistant; 300-bed general hospital in city of about 300,000; $4800 start. (h) South; teaching dietitian; direct dietetic interns and student nurses; supervise writing of special diets; 200-bed hospital in historic city of about 70,000.

MEDICAL RECORD LIBRARIANS—(a) Chief; middle east; large hospital, fully approved; record department is well organized with a staff of 14; present chief is retiring after nine years; an unusually fine position. (b) California; 100-bed hospital in town of 14,000; $4800. (c) Chief; east; 100-bed hospital on Atlantic sea coast; registered preferred, but will consider without. (d) Chief; southeast; 250-bed hospital in winter resort area; $4800. (e) Chief; middle west; 200-bed hospital; 4 in department; to $5100. (f) Chief; large teaching hospital; $5500. (g) Chief; middle west 250-bed hospital; to $6000; (h) Assistant; middle west; 60-bed hospital in city of 25,000; Micro-film records; $3600 to start. (i) East; chief; 300-bed teaching hospital—14 employees in department; to $5000.

SHAY—*Continued*

(j) Chief; 350-bed hospital in large university city; 12 in department; $5000. (k) Chief; middle east; good experience in supervision and thorough knowledge of standard nomenclature; 5 in department; $5300. (l) Chief; middle west; 250-bed hospital. 5 medical stenographers, one clerk typist in department; $5100. (m) East; 350-bed teaching hospital, nine in department; $5100.

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Day, Director
332 Bulkley Building
Cleveland, Ohio

EXECUTIVE HOUSEKEEPER — (a) 200-bed hospital, Conn. (b) 350-bed mid-western hospital. (c) 225-bed hospital, south. (d) 300-bed hospital, New York State.

ADMINISTRATIVE ASSISTANT — (a) 300-bed hospital, large medical center, Ohio (b) 400-bed mid-western hospital. (c) 85-bed new modern hospital, east.

EXECUTIVE DIRECTOR—(a) 115-bed general-chronic hospital; west. (b) 50-bed hospital, southeast; R.N. considered. (c) 250-bed hospital, resort area, south. (d) 80-bed hospital, Pennsylvania; expansion planned.

ADMINISTRATOR—(a) 135-bed hospital, New York; living quarters for single man or woman. (b) 40-bed Ohio hospital. (c) 60-bed hospitals, west and west coast.

PERSONNEL DIRECTORS—275-bed mid-western hospitals.

BUSINESS MANAGER — 200-bed hospital; east.

DIRECTOR, NURSING EDUCATION — (a) 250-bed hospital, south; progressive community. (b) 175-bed hospital, east. (c) 315-bed hospital, mid-western university city.

DIRECTOR, NURSING SERVICE—(a) 200-bed Ohio hospital; $6,000. (b) 150-bed hospital, Virginia.

RECORD LIBRARIAN CHIEF — (a) $5400, Ohio. (b) Dietitians: $350-$425. (d) Laboratory technicians; X-ray technicians. (e) Anesthetists; all locations.

PLACEMENT BUREAUS

MARY A. JOHNSON ASSOCIATES
11 West 42 Street New York 36, N.Y.

Mary A. Johnson, Ph.D., Director

FINE SCREENING BRINGS BEST RESULTS
Our careful study of positions and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefully evaluated to individual situations, and only those who qualify are recommended. Our proven methods shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidate for the position and the best job for the candidate, we prefer to keep our listings strictly confidential.

We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists, and other supervisory personnel.

No registration fee

Agency

(Continued on page 214)

PLACEMENT BUREAUS

MEDICAL EMPLOYMENT SERVICE
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ANdover 3-5663-64

Alfred E. Riley, R.N., MSHA Director
Dorothea Bowlby, Counselor

"All that the Name signifies." A competent service for both Employer and Employee, with selective screening, carefully prepared credentials and each position evaluated to individual situation, saving needless interviews, correspondence and time for all. Our listings are confidential and you will appreciate our human understanding and personal approach to your problem. We have opportunities and available positions suitable to your education, experience and talents for Administrators, Physicians, Dentists, Anesthetists, Directors of Nursing, Medical Technologists, Therapists and other supervisory hospital personnel.

HOSPITAL PERSONNEL BUREAU

Knickerbocker Bldg. 218 E. Lexington St.

Baltimore 2, Maryland

"LExington 9-5029"

Chas. J. Cotter, Director
(Former Administrator)

Nation-wide placement service for Physicians, Administrators, Anesthetists, Dietitians, Nurses, Technicians, Pharmacists, Comptrollers, Accountants, Secretary, Housekeepers, etc.

Mail resume, 5 photos, salary.

No Registration Fee. Licensed Employment Agent.

(formerly Hagerstown, Maryland)

INDIANA MEDICAL BUREAU
212 Bankers Trust Bldg.
Indianapolis, Indiana

Opportunities in most areas for Administrators, Medical Directors, Anesthesiologists, Pathologists, Radiologists, Resident Physicians, Laboratory and X-Ray Technicians, Therapists, Medical Records Librarians, and all areas of supervisory hospital and medical personnel.

classified advertising

PLACEMENT BUREAUS

Information about

GUALIFIED NURSE PERSONNEL

is available from the

American Nurses' Association

PROFESSIONAL COUNSELING & PLACEMENT SERVICE

37 So. Wabash Ave.

Chicago 3, Ill.

STate 2-8883

MEDICAL—DENTAL—HOSPITAL personnel openings. Top salaries. Professional Placement, 1835 Eye St., N.W., Washington 6, D.C. (First Floor)

FOR SALE

New and used hospital equipment bought and sold. Large stock on hand for the physician, hospital and laboratory. Write for what you want or have for sale.

HARRY D. WELLS

409 East 59th Street, New York City

FOR SALE

NURSING AND MEDICAL BOOKS

We have in stock every nursing or medical book published. Lowest prices with unexcelled service. Write Chicago Medical Book Company, Jackson and Honore Streets, Chicago 12, Illinois.

SCANLON-MORRIS UROLOGICAL TABLE, Style A-32, complete with stirrups and L-F Bucky. Original $845 in 1950. Used very little. Contact Administrator, Lawrence County General Hospital, Ironton, Ohio.

GOVERNMENT SURPLUS

X-Ray and medical equipment, operating tables, lights, sterilizers and autoclaves. Write for new X-Ray accessory price list. MEDICAL SALVAGE CO., INC., 217 E. 23rd St., New York 10, N.Y.

Approximately 100 SIMMONS FORD MODEL METAL BEDS with gatch spring. Excellent buy at $35.00 each. Henry Ford Hospital, Purchasing Department, Detroit 2, Michigan.

(Continued on page 216)

MISCELLANEOUS

REGISTERED STAFF NURSES

NEVER A DULL MOMENT FOR THE GRADUATE NURSES who decide they would like to join us at the University of Texas Medical Branch Hospitals. We work a 40 hour week in our air conditioned hospitals, leaving 168 hours to enjoy the beach and nearby resorts. Galveston boasts an average temperature in the low seventies which means that swimming, fishing, horseback riding and sailing can be enjoyed the year round.

We have positions available in the clinical area of your choice. Our staff nurses monthly salaries begin at $264 for rotation and $277 for extended evenings or nights. Uniforms are laundered free. We have liberal personnel policies and opportunities for advancement. Comfortable air conditioned residences including maid service are available at moderate cost. There are excellent opportunities for advanced study leading to both B.S. and M.S. degrees.

Write for further information to the: Director of Nursing Service, University of Texas Medical Branch Hospitals, Galveston, Texas.

classified advertising

SCHOOLS—SPECIAL INSTRUCTION

The CHICAGO LYING-IN HOSPITAL AND DISPENSARY of the University of Chicago offers a six-months course in OBSTETRIC NURSING to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Ill.

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Missouri.

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $75.00 a month is provided. For full information, apply to the Director of Nurses, Providence Lying-In Hospital, Providence 8, Rhode Island.

GRADUATE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA offers a four month course in operating room technic and management to registered graduates of accredited schools of nursing. Registration fee $20.00. Full maintenance and $30.00 monthly cash allowance given. Apply to Director of Nursing Service, 1818 Lombard Street, Philadelphia 46, Pennsylvania.

NEW YORK UNIVERSITY offers to qualified registered nurses, who meet admission requirements of the Department of Nurse Education, School of Education, a one year's internship in Clinical Nursing at James Ewing Hospital of the Department of Hospitals, Memorial Center. Experiences include cancer chemotherapy, medicine, surgery, rehabilitation and principles of team nursing. A monthly stipend, laundry and two meals a day are provided. Students will be assisted in securing desirable living accommodations. Classes are accepted in February and September. For further information write to Rosemary Bouchard, Director of the Internship Program, Department of Nurse Education, School of Education, New York University, Washington Square, New York 3, New York.

EXCLUSIVELY IN GOLD SEAL NAIRON CUSTOM "VENETIAN"... A MARBLE DESIGN IN THE LUXURIOUS ITALIAN MANNER

NEW Gold Seal NAIRON* CUSTOM

This magnificent new ⅛" plastic floor tile offers true beauty and elegance of design and color—yet is unsurpassed in ruggedness. It will compliment the finest interior . . . give amazing service in the busiest kitchen or corridor!

Of premium quality, Gold Seal Nairon Custom is super-resistant to abrasion, chemicals, grease, oils and solvents. Maintenance is the easiest ever! The non-porous satin-smooth surface wipes clean and sparkling with a damp mop. To speed cleaning of stubborn grime, strong detergents and soaps can be used without fear of damage. Highly flexible—Nairon Custom resists indentation better than other resilient flooring. In addition, Congoleum-Nairn research "know-how" has built exceptional dimensional stability into this product. For more information, write to Customer Service Department, Congoleum-Nairn Inc., Kearny, N. J.

SPECIFICATIONS: Install over on-grade concrete, suspended wood or suspended concrete.

"*Venetian*"— 5 colors—⅛"
"*Sequin*" —19 colors—⅛" and .080"
"*Marble*" — 7 colors—⅛" and .080"

All ⅛" tile available in 9" x 9", 12" x 12" and 18" x 18". The .080" tile offered in 9" x 9" only.

FOR HOME OR BUSINESS:

INLAID BY THE YARD—Linoleum • Nairon® Standard • Nairontop®
RESILIENT TILES—Rubber • Cork • Nairon Custom • Nairon Standard
Vinylbest • Linoleum • Ranchtile® Linoleum • Asphalt
PRINTED FLOOR AND WALL COVERINGS—
Congoleum® and Congowall®
RUGS AND BROADLOOM—LoomWeve*

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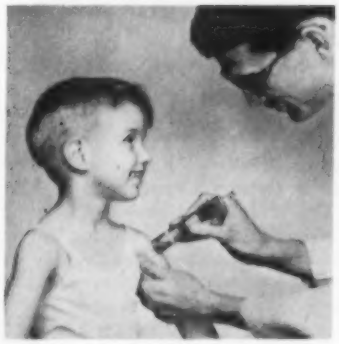
FOR THE LOOK THAT'S YEARS AHEAD
Gold Seal® FLOORS AND WALLS

*Trademark

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form opposite page 236. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Automatic Injector Device Has Hidden Needle



A "hidden needle" device, called the B-D Presto Injector, completely conceals the needle in the hypodermic injector, thus minimizing the pain and fear of injections. The needle is automatically triggered when the circular rubber foot is pressed against the skin. The Presto is designed only for subcutaneous and intramuscular injections, is small, light and comparatively easy to use. It is designed to be used with Luer-Lok syringes only; either Multifit or Yale. Other features of the Presto are speed of needle penetration and "pressure anesthesia" when the rubber foot is pressed against the skin and masks the point of needle stimulus. **Becton, Dickinson & Co., Rutherford, N.J.**

For more details circle #426 on mailing card.

Low-Cost Fire Alarm Is Automatic

Low cost, low-voltage installation wiring is used for the new Edwards automatic fire locator and fire alarm system. The announcement states that the system has approval of the National Fire Protection Association and the National Board of Fire Underwriters. It is also available for operation from stand-by batteries in case of failure of the light and power service.

Indicator lamps on the control panel show the location—a floor, wing, group of rooms, storage or other area—should fire start. Audible alarms sound throughout the building to alert personnel. The entire system is electrically supervised, a trouble bell sounding automatically in case of a fault in the wiring. **Edwards Company, Inc., Norwalk, Conn.**

For more details circle #427 on mailing card.

Dixie Dispenser for Medicine Cups

Medicine cups can now be readily available at any convenient place in the hospital with the new Dixie Dispenser designed especially for one ounce medicine and condiment cups. Made of clear, durable plastic, the new dispenser holds 100 Dixie cups. It is easy to mount and clean and will also dispense the two and three ounce sizes in Dixie cups. **Dixie Cup Corp., Easton, Pa.**

For more details circle #428 on mailing card.

Surgical Gut in Transparent Plastic Envelope

A new method of packaging sterile surgical gut sutures is offered in Surgilar Sterile Pack. The hazard of broken glass is removed from surgery by the new package which seals 54 inches of heat-sterilized surgical gut in a transparent plastic envelope. This, in turn, is enclosed in a glassine envelope. The strands of sterile surgical gut are doubled to 27 inch lengths, coiled, and placed in the

fold of an identifying label. The size of the sterile plastic envelope allows the gut to coil naturally, without constriction. Handling is at a minimum and kinks are eliminated, making a strong, flexible strand of gut ready for the surgeon.

A wide-mouthed jar filled with a sterilizing solution holds 36 double envelopes. Up to eight envelopes can be removed at one time by forceps, using routine aseptic technic. The tops of both envelopes are cut with one snip of the scissors and the suture nurse grasps the gut coil by its label. Unused envelopes may be returned to the Surgilar jar solution with sterile forceps after removal of the protective outer envelope. The Surgilar solution will restore the sterility of the exterior of the plastic envelope in two hours, it is said. The new packaging cuts preparation time and saves storage space. **Davis & Geck, Inc., A Unit of American Cyanamid Co., Danbury, Conn.**

For more details circle #429 on mailing card.

(Continued on page 220)

Increased Light in Redesigned Fluorescent Lamp

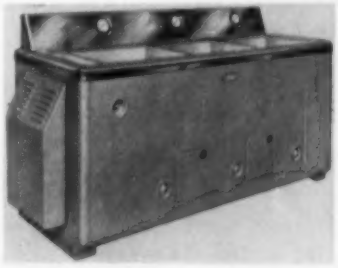
Double the light output of tubes of equal length is claimed for the new General Electric Fluorescent lamp. A revolutionary change in tube design is responsible for the improvement. It features a series of lengthwise dents or grooves along one side of the eight foot tube. The greater light output is said to result from an increase in area of the lighted tube surface, the higher wattage at which the new tube can be operated, and the more effective use of energy within the tube. Known as Power-Groove, the new lamps achieve the gain in light output with no loss in efficiency. **General Electric Company, Nela Park, Cleveland 12, Ohio.**

For more details circle #430 on mailing card.

Kewanee Dishwasher Provides Extra Rinsing

Three full-sized tubs are provided in the new Kewanee Dishwasher, one for wash and two for rinsing. The double-rinsing possible with the two rinse tubs provides an extra sanitary precaution in dish handling in institutions. A shallow gross soil compartment for removal of waste food from dishes prior to washing is also provided.

Tubs and compartment in the new dishwashers are of stainless steel with corners rounded for easy cleaning. The dishwasher has a recessed thermometer bulb and hidden thermostat to prevent any projection into the tubs, with overflow and stopper for each tub. Wash water can be regulated from 120 to 160 degrees with rinse water heated to 180 degrees for positive sanitation. Left-to-



right and right-to-left operational types are available in the new three-tub as in all Kewanee dishwashers. **Kewanee Industrial Washer Corp., Kewanee, Ill.**

For more details circle #431 on mailing card.

WHAT'S NEW

Instrument Sterilizer Operates Automatically

A turbulent washing action followed by pressure steam sterilization at 270

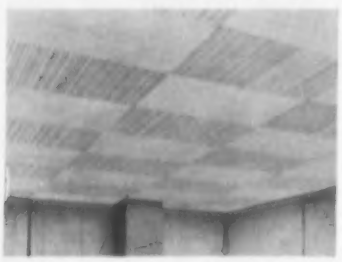
degrees F. clean and sterilize surgical instruments in minimum time. The new Automatic Washer-Pressure Sterilizer is designed for fast handling of instruments following surgery. It may also be used for three-minute emergency or seven-minute sterilization of unwrapped instruments. With average steam and water supply the machine will handle two trays of instruments in 22 minutes due to its completely automatic washing-sterilizing cycle. Loading trays are interchangeable with those used in the American High-Speed Instrument Sterilizer.

Personnel time in scrubbing instruments by hand is saved when the new Washer-Sterilizer is used following surgery. A special safety lock prevents starting the machine until the door is closed and sealed. The door remains locked until the cycle is completed, the steam exhausted and the switch turned to "off." Installation can be simply made at any convenient location in the surgical suite as a condenser exhaust eliminates need for a vent stack connection. **American Sterilizer Co., Erie, Pa.**

For more details circle #432 on mailing card.

Mineral Fiber Tile Is Incombustible

Crestone is a new mineral fiber acoustical tile with a new acoustical design. Striated to create a textured surface, the ridges and valleys of the material form strong directional lines of high light and



shadow for ceiling interest. The striated surface pattern offers a variety of design possibilities. Rated as incombustible under Federal Specifications, according to the manufacturer, Crestone can be used where construction must conform to rigid building codes requiring a fire-safe material.

Surface-finished with two coats of white latex paint, Crestone has a light reflection coefficient of 70 per cent. Light is evenly diffused by the striations of the material, minimizing the possibility of glare. Crestone is easily installed, can be repainted without affecting the sound-absorbancy, and can be cleaned with a vacuum or wallpaper cleaner. It is available in 12 by 12 and 12 by 24 sizes. **Armstrong Cork Co., Lancaster, Pa.**

For more details circle #433 on mailing card.

Plastic Container for Gravity Blood Collection

The new Pliapak is a plastic container for gravity blood collection. It is a disposable, non-wettable, pliant and tamper-proof plastic bag for collection of 450 cc. of blood. It can be centrifuged in a standard 500 cc water-filled cup and is designed to save space. It is easy to

handle as the self-collapsing Pliapak bag obviates the need for air-intake needle and eliminates the risk of air embolism. Pliapak permits the application of external pressure for transfusion.

The 450 cc Pliapak with Blood Collection Set consists of the Pliapak and 36 inches of plastic tubing, pinch clamp and attached silicone-treated 15 gauge stopper-piercing needle and 15 gauge vein needle. **Abbott Laboratories, North Chicago, Ill.**

For more details circle #434 on mailing card.

Instrument Washer-Sterilizer Operates Automatically

The new Castle "200" automatic Instrument Washer-Sterilizer provides fast, safe pre-operative processing and post-operative clean-up. A motor-driven valve selector governs the entire cycle. In one complete, automatic operation soiled instruments direct from surgery are jet rinsed, scoured, sterilized and flash-dried for immediate re-use or storage. A soak period of any time up to 30 minutes is automatically included by setting the built-in timer prior to pressing the start button. The unit can be manually oper-

ated for Hi-Speed Emergency Sterilization by turning a switch.

The processing system is designed to protect instruments by reducing handling and hand scrubbing. The cleaning technic reaches every crevice without scratching or damaging instruments. During the cleaning and sterilizing process the operator is free for other duties. The Monel tank holds two extra-large Monel instrument trays during cycle. The quick heating feature makes it possible to complete the cycle in fifteen minutes. Instruments are sterilized at 270 degrees F. and the tank is drained automatically under pressure. The device is operated by a single push-button control above the door. **Wilmot Castle Co., P. O. Box 629, Rochester 2, N.Y.**

For more details circle #435 on mailing card.

Small-Sized Tote Box of Wear-Ever Aluminum

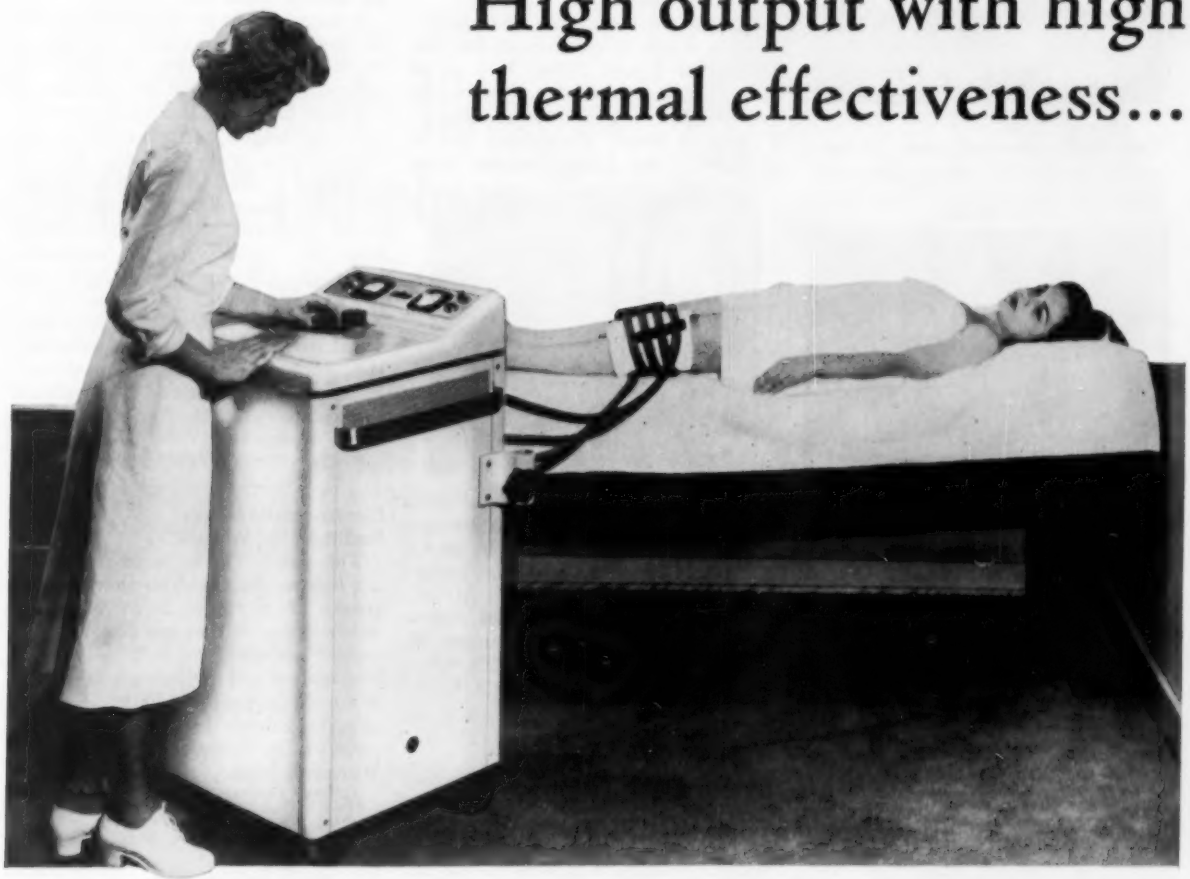
Designed for use in transporting and storing meats, poultry, fruit, vegetables and other foods, the new Wear-Ever Aluminum Tote Box is light in weight and easy to handle. The small-sized box is 24 inches long and has a width outside top of 16⅛ inches. It is designed for secure stacking when filled and space-saving nesting when empty. It is easy to lift and carry the small-sized Tote-Box, even when filled. Boxes can be stamped at the factory with name and checking

numbers without extra cost, thus reducing the danger of loss. **The Aluminum Cooking Utensil Co., Inc., New Kensington, Pa.**

For more details circle #436 on mailing card.

(Continued on page 222)

High output with high thermal effectiveness...



with the new G-E F-III Inductotherm®

YOU'LL appreciate the ease and facility this new G-E Inductotherm diathermy unit offers for administering the full range of treatments. Clean, modern, functional design puts controls at your finger tips for ease of use and maximum visibility. No bending to read dials — no reaching past electrodes to set controls.

Basic unit includes a fully-adjustable contour-following electrode. Optional are the 12-foot cable electrode (illustrated), fully-adjustable air-spaced electrodes, and an electrosurgical kit.

Add to these features the F-III's output of 225 watts plus high thermal effectiveness — and you have a diathermy unit which efficiently delivers large doses of heat to the deep vascular tissues.

You'll be surprised to learn how little your investment will be when you add the G-E F-III Inductotherm to your practice. Get all the facts from your nearby G-E x-ray representative. Or write General Electric Company, X-Ray Department, Milwaukee 1, Wisconsin, for Pub. H-85.

G-E advanced engineering gives you this too:

- Crystal oscillator circuit assures consistent operation at internationally approved frequency.
- Electrodes attach to *rear* of unit — no cable interference.
- Convenient switch cord lets patient shut off unit at any time. Preset timer automatically ends treatment.

Progress Is Our Most Important Product

GENERAL ELECTRIC

WHAT'S NEW

Pipette Drier Operates Electrically

Pipettes are thoroughly and quickly dried at a safe temperature in the new SP Electric Pipette Drier. It is of all stainless steel construction, designed to accommodate any size pipette up to 375 mm in length. Continuous flow of air through the drying chamber is ensured by a vent in the base. Side walls do not get hot because of this arrangement. A pilot light is mounted on the base and the cord has an on-off switch. The drier operates on 115 V. AC-DC. **Scientific Products, Division of American Hospital Supply Corp., Evanston, Ill.**

For more details circle #437 on mailing card.

Polisher-Scrubber for Hard-to-Reach Areas

A fully pivotal handle and compact housing (8⅞ inches from floor to top of housing) feature General Floorcraft's new semi-commercial Twin-16B Polisher-Scrubber, making it possible for the machine to get under most furnishings and reach inaccessible corners.

Counter-rotating intermeshing brushes provide a 16 inch spread. Brushes are driven by a full rated, ½ h.p. Universal type 110 volt AC-DC motor. The Twin-16B is equipped with a 30 foot cable and may be used for waxing, buffing, scrubbing, polishing, refinishing, dry cleaning and sanding. **General Floorcraft, Inc., 421 Hudson St., New York 14.**

For more details circle #438 on mailing card.

Hearing Aid Fits Eye Glasses

A complete 4-transistor hearing aid is now available that fits quickly and easily on the wearer's spectacles. It weighs less than one ounce and can be attached to any glasses. The end of the bow behind the ear is removed and the tiny hearing aid slipped on, actually replacing the curved portion of the spectacle ear piece. It blends into the frame of the glasses, making it practically unnoticeable when worn by a man and it is hidden by a woman's hair. When worn on both ear pieces, the user obtains directional hearing and a fuller, more natural tone quality. **Telex, Inc., 1633 Eustis St., St. Paul 1, Minn.**

For more details circle #439 on mailing card.

Type PB Luminaires for Institutional Use

A complete line of fluorescent fixtures for institutional installations is offered in the new Type PB Westinghouse luminaires. The units are available in two and four lamp models in four or eight foot lengths, for mounting in continuous rows or individually, and for rapid start or slimline lamps. Soft, glare-free, semi-indirect lighting with maximum freedom from shadows results from the combination of suspension mounting, a strong upward light component and a translucent plastic bottom. Each luminaire consists of a completely wired steel channel, an easily removable channel cover and an extruded one-piece polystyrene shield. **Westinghouse Electric Corp., P.O. Box 2099, Pittsburgh 30, Pa.**

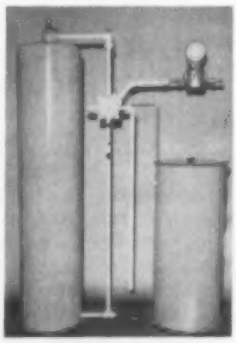
For more details circle #440 on mailing card.

Electrocardiograph Reduced in Weight

The new ECG-260 Electrocardiograph is a lightweight model weighing only 25 pounds. It is 8½ by 14 by 9⅜ inches in size and is conveniently portable. The controls are simplified by a push-button lead selector and the instrument, housed in a mahogany cabinet, has the precision of earlier models developed by the company. **Edin Company, 207 Main St., Worcester, Mass.**

For more details circle #441 on mailing card.

Water Softener for Small Institutions

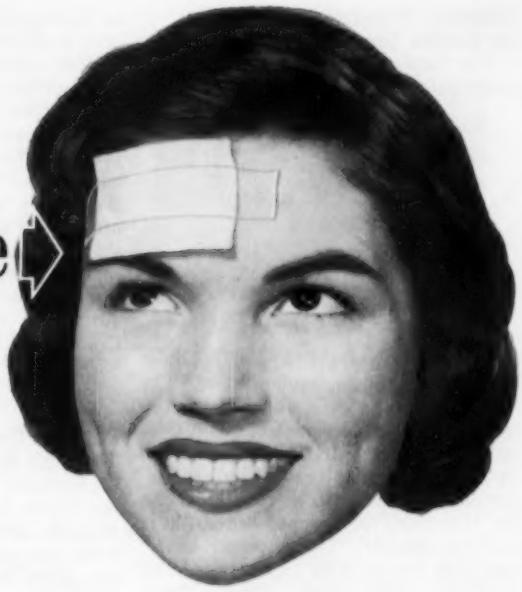


Designed for use in small hospitals and other institutions, the special line of new Elgin water softeners employs the Elgin "Double-Check" design. Increased water softening capacity is assured without the loss of zeolite. Also standard equipment on the new softeners are the Elgin Multiport Valve, bell alarm meter and brine tank. The special meter is wired to ring when the desired gallonage of water passes through. Capacities range from 28,000 to 91,000 grains with synthetic gel zeolite and from 54,000 to 180,000 grains with resinous ion exchanger. **Elgin Softener Corp., Elgin, Ill.**

For more details circle #442 on mailing card.

(Continued on page 224)

Everybody likes "SCOTCH" Cellophane Tape for bandaging!



Looks better! Bandages applied with "SCOTCH" Brand Tape are neater, more attractive. Mirror-smooth surface stays clean longer, too.

Holds tight! Even in active work or play, "SCOTCH" Cellophane Tape sticks tight. And its adhesive is non-irritating.

Peels off painlessly! Youngsters like the fast, easy way "SCOTCH" Brand Tape peels off when bandages are changed. For neat, dependable bandaging, try the tape of 1,000 uses . . .

REG. U. S. PAT. OFF.

SCOTCH BRAND

Cellophane Tape

PRODUCT OF 3M RESEARCH

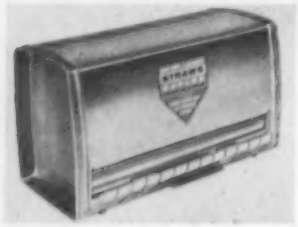
3M COMPANY

The term "SCOTCH" is a registered trademark of Minnesota Mining and Manufacturing Company, St. Paul 6, Minn. Export Sales Office: 99 Park Ave., New York 16, N.Y. In Canada: P.O. Box 757, London, Ontario.

WHAT'S NEW

Sanitary Dispenser for Jumbo Unwrapped Straws

The Duplex Straw Dispenser is now available in the JS-20 Jumbo Model for



dispensing unwrapped 6½, 8½ Jumbo and 8½ inch Super Jumbo Straws. The all stainless steel device dispenses one unwrapped straw at a time from both sides of the dispenser with complete sanitation. It was developed to health board specifications and is designed to reduce the cost by dispensing unwrapped straws in a sanitary manner. The dispenser is also available for use with regular sized and ordinary jumbo straws. **Duplex Straw Dispenser Co., 511 N. La Cienega Blvd., Los Angeles 48, Calif.**

For more details circle #443 on mailing card.

Shower Control Unit Is Self-Contained

The Leonard G.S. Control Unit is a self-contained water temperature control for institutional showers. The preassembled, factory-tested unit is ready for immediate installation. All necessary fittings are assembled in a locked, vandal-proof steel cabinet with a removable black Formica panel board. Three couplings make up the plumbing connections and all parts can be easily replaced on the job if necessary, without disturbing pipe connections. The G.S. unit is available for six standard sizes for group or gang control in modern cabinets finished in colors to match the shower room. **Leonard Valve Co., 1360 Elmwood Ave., Cranston 7, R.I.**

For more details circle #444 on mailing card.

Patients Get Natural Foods Through Barron Pump

Developed by James Barron, M.D., of the Henry Ford Hospital, Detroit, with research and mechanical development under the guidance of James C. Zeder of the Chrysler Corporation, the Barron Food Pump is the result of extensive study and experience in patient feeding problems. The new model of the pump is the result of five years of operation and development. It makes possible the feeding of natural foods by pumping them into the patient's stomach.

The Barron Food Pump is designed to give an adjustable controlled administration of liquefied natural foods through a small caliber plastic intubation tube at a regular constant rate of delivery while the patient is allowed to sit up, lie down, or turn on either side as desired. Through the method, upper gastrointestinal fluids containing essential electrolytes, enzymes and other properties can be returned to the body by adding them to the food bottle. Food is specially prepared for intubation and minimum nursing care is required for feeding cases. The 2.5 mm plastic intubation tube is readily accepted by the patient who receives natural food directly in the

stomach with no distress or discomfort. The pump operates silently and affords controlled forced tube feeding with minimum patient discomfort and nursing care. **Abco Dealers, Inc., 41 E. 42nd St., New York 17.**

For more details circle #445 on mailing card.

WHAT'S NEW

Oxygen Analyzer Is Portable and Quick

A lightweight, battery-operated electronic oxygen analyzer is now available which can be easily carried to place of need. The simplified operation permits even inexeprienced personnel to get accurate readings within 30 seconds. Should the need arise, it is easily recalibrated within a few minutes.

The new O.E.M. Electronic Oxygen Analyzer facilitates frequent routine checking of oxygen concentration in hood and tent therapy and in premature

nurseries. The unit is electronically activated with a 4½ volt portable radio A battery that is described as sufficient for up to 5000 tests. **The O.E.M. Corporation, East Norwalk, Conn.**

For more details circle #446 on mailing card.

Room Air Conditioners Require Minimum Electricity

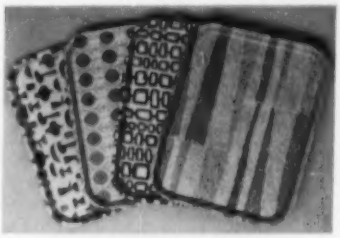
Improved efficiency of the compressor and fan motor permits the two new Yorkaire Room Air Conditioners to require little more than half the electricity normally required, according to reports. Therefore units can be installed without rewiring or installation of outlets.

The ½ and ¾ h.p. Yorkaire units are simple to operate with a single dial controlling the fan motor, cooling and dehumidifying. An automatic thermostat shuts off the cool air when a designated temperature is reached. All controls are protected by an attractive cover to prevent tampering. The units may be mounted flush with draperies inside the room or flush with the building outside. **York Corporation, York, Pa.**

For more details circle #447 on mailing card.

Decorated Trays Give Cheerful Touch

Attractive designs are used on the new Tempo-Trays for food service. They add a cheerful, decorative note to patient trays and are styled to harmonize with modern decor. The trays are offered in twelve different patterns, each in a choice of three color combinations. Trays illustrated were designed by such well known artists as George Nelson and Paul McCobb. Also in the line are trays designed by Salvador Dali, Isamu Noguchi and other leading designers. The new Bolta Tempo-Trays have all of the durability



and other excellent qualities of undecorated Bolta trays. **Bolta Products, Lawrence, Mass.**

For more details circle #448 on mailing card.

Quarry Tile Now Available in Bluegrass Green

An addition to the line of ceramic tile products offered by Mosaic Tile Company is the new Bluegrass Green Quarry Tile. The bluish green effect in the new tile can neither fade nor wear off since it completely permeates the product. Heavy traffic floors of the new tile will thus keep their attractive color even after long wear. The new color harmonizes with other tile shades and provides a neutral background for furniture and furnishings. **The Mosaic Tile Company, Zanesville, Ohio.**

For more details circle #149 on mailing card.

(Continued on page 226)

WHAT'S NEW

Upholstered Folding Chair of Lightweight Aluminum

B. F. Goodrich foam rubber is used with vinyl fabric upholstery material to

give maximum seating comfort in the new Beam folding chairs. The upholstery, which is available in charcoal heather, coral heather, black, red and green, can be easily cleaned by wiping. The frames are of tubular aluminum, making the chairs light and easy to handle. They fold in one quick motion for compact storage and frames are rust and corrosion resistant, highly polished aluminum. The chairs are 32 inches high and have a 16 inch square seat. **Beam Metal Specialties, 25-11 49th St., Long Island City 3, N.Y.**

For more details circle #450 on mailing card.

Dual Systems in Royal-Aire Conditioners

The new ten and fifteen ton self-contained air conditioners in the Royal-Aire line for institutional use are equipped with a pump-down control system ensuring a minimum of gas remaining at low pressure in the coils when the machine shuts down. Each unit has two accessible hermetic compressors and dual condenser circuits. The dual system gives complete control of both temperature and humidity. Under light load conditions only one system operates but in cases of extreme heat and high humidity both operate automatically.

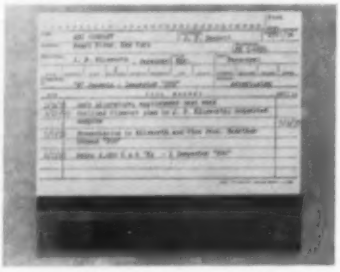
The Unarco Royal-Aire has a standard vertical fan discharge but can be provided with a horizontal, rear fan discharge for use with duct work, as optional equipment. It can also be furnished with single two-state thermostat. Extruded aluminum air foil louvers are installed in the discharge grille to eliminate the possibility of rust, discoloration or deterioration. The two-tone semi-gloss baked enamel housing is finished in gray with gold trim above the double fluting on the front panel. Controls are located at a convenient level to eliminate stooping or bending. **Union Asbestos & Rubber Co., Heating and Cooling Div., 332 S. Michigan Ave., Chicago 7.**

For more details circle #451 on mailing card.

Microfilm System for Existing Records

Filmsort Transtrip is a new technic for using microfilm with existing records. A clear acetate jacket known as the Filmsort Transtrip is combined with individual pockets or chambers for 16 mm or 35 mm film with a special adhesive strip for attaching to file folders or cards in existing systems.

The new system was developed for use where there is a high rate of referrals. A quantity of information, records, copies and the like can be added to existing records without materially increasing their bulk, with the Filmsort Transtrip method. Filmsort readers or Filmsort Micro Midget can be used to



view individual pieces of film without removal from the jacket. **Filmsort Div., Dexter Folder Co., 30 S. Pearl St., Pearl River, N.Y.**

For more details circle #452 on mailing card.

WHAT'S NEW

Instant Sanka Available In Paired Packages

Cup size Instant Sanka Coffee Packages are now available in pairs for the convenience of those institutions serving coffee in 10 to 12 ounce pots. Each carton of the new packages contains a supply of identification rings for use on the serving pots. **General Foods Corp., White Plains, N.Y.**

For more details circle #453 on mailing card.

Trend China Shape Improves Tray Setting

Food trays set with the streamlined Syracuse Trend China do not look crowded and have room for all needed pieces. The square-round shape is functional, giving full food-serving area in small overall diameter. The attractive Syracuse Berkley Pattern in Trend China shown in the illustration makes an effective tray setting. Trend China also saves space when used in lunchrooms and other dining areas. The china is sturdy and easy to handle and is designed for institutional food service. **Onondaga Pottery Co., Syracuse, N.Y.**

For more details circle #454 on mailing card.

Plastic Containers for Blood Collection

The new Saftiflex is a plastic container for blood collection and administration. It is said to extend platelet preservation two to three days, there is practically no foaming or clot formation, and the blood has greater oxygen-carrying capacity even after storage. Saftiflex permits a completely closed system during withdrawals and administration, eliminating the possibility of air embolism. The positive seal diaphragm permits plasma aspiration without contamination and there is no change necessary in the technic. The Cutter Saftiflex is made from sturdy, transparent polyvinyl chloride and remains flexible even at 0 degree Centigrade. **Cutter Laboratories, Berkeley 1, Calif.**

For more details circle #455 on mailing card.

Water and Ice Storage in Self-Contained Unit

A completely self-contained unit for water service and ice is offered in the Electric Fill B-1280 Water Station and Ice Storage Chest. Water flow is instantaneous in on and off operation when the electric eye beam is broken by a paper cup, glass or pitcher. The ⅓ h.p. compressor is an instantaneous cooler, chilling 15 gallons of water per hour. The unit is ready for operation when attached to water and power sources. It has a working height of 36 inches and is 24 inches square, with adjustable legs. Ends and back are Duco finished and the front and top are stainless steel. It is also available without the ice storage chest. **T & S Brass & Bronze Works, Inc., 32 Urban Ave., Westbury, N.Y.**

For more details circle #456 on mailing card.

(Continued on page 228)

WHAT'S NEW

Simple Operation and Low Cost in Verifax Signet Copier

The new Verifax Signet Copier is designed to produce a number of copies of any written, typed or printed material up to legal size in one minute. The low-cost unit is simple to operate and produces copies at minimum cost per unit for materials. Correspondence, administrative and laboratory reports, records, charts, articles from journals and other documents can be copied quickly by any employee after a few minutes of instruction.

In addition to regular Verifax Copy Paper and the relatively new Verifax Translucent Copy Paper for printing intermediates or masters for use in diazo-type printers, the suitable papers are also available in card weight, in lightweight for airmail use, and in blue and yellow for color-coding of copies or other special applications. Offset plates for office-type duplicators can also be made with it. **Eastman Kodak Company, Business Methods Sales Div., Rochester 4, N.Y.**

For more details circle #457 on mailing card.

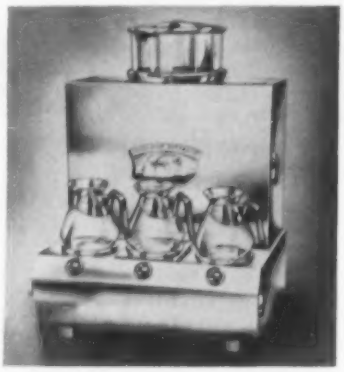
Universal Wrench for Orthopedic Appliances

A new universal wrench that combines four tools in one is designed to fit all major bolt head types on orthopedic fixation appliances. Made of stainless steel, fully cannulated, the Orthopedic Universal Wrench No. 381-U has four arms and is nine inches across. Wrench openings fit hex bolts in four sizes, from ¼ to ½ inch in diameter. **Orthopedic Equipment Co., Bourbon, Ind.**

For more details circle #458 on mailing card.

Hill-Shaw Vaculator Brews Coffee Automatically

The VAC-100 is a fully automatic coffee brewing system holding five pounds of fine-grind coffee. More than 13 gallons of coffee can be made with one filling. The machine is filled, the starting button is pushed and the machine measures the coffee, brews it and cleans out the grounds. A pot of coffee is made automatically in three minutes. A built-in coffee dispenser gives portion control with exact measures of coffee at all times. The brewing chamber is attached to a motor-driven turntable which moves counter-clockwise to receive the coffee, lock the brewing chamber and empty the finished coffee into the decanter. When the coffee-making cycle is finished, grounds are automatically rinsed away into the waste drawer with cold water, eliminating any danger of



burns from hot coffee grounds. The grounds need be emptied only once for five pounds of coffee. **Hill-Shaw Co., 311 N. Desplaines St., Chicago 6.**

For more details circle #459 on mailing card.

WHAT'S NEW

Pleural Suction Pump Has Mobile Stand

A mobile stand which supports two trap bottles as part of the unit holds the new Emerson Pleural Suction Pump. The triangular base, mounted on casters, makes it easy to move the pump to the recovery room or ward for bedside use. It operates quietly and is designed for continuous service over long periods.

The pump moves the maximum amount of air to maintain negativity in the intrapleural space. Set at —10 centi-

meters of water it aspirates at the rate of 30 liters per minute and at —20, at the rate of 50. If one or both of the small tubes provided for connection to the patient should become obstructed, there is no appreciable rise in pressure, eliminating the danger of causing intrapleural leakage. Visual indication of operation is provided to protect the patient in the event of inadvertent disconnection of the electric circuit. Two small tubes may be connected to drainage catheters in one or two patients. They are of plastic, sufficiently transparent to permit clots to be seen, and can be autoclaved. **J. H. Emercon Co., 22 Cottage Park Ave., Cambridge 40, Mass.**

For more details circle #460 on mailing card.

Disposable Petri Dish Combined With Culture Medium

A covered, optically clear, scratch-free plastic petri dish containing an agar of 10 per cent defibrinated sheep blood in a beef heart infusion base makes up the new Pre-Med unit. This prepared medium combines the advantages of a "ready-to-streak" blood agar culture medium with the plastic, disposable petri dish. The plates are ready for immediate use, each packaged in a sterile polyethylene bag in which the streaked plate may be resealed if prolonged incubation is desirable. Time is saved in obtaining suitable blood, in mixing and pouring the medium and in cleaning petri dishes. **Hyland Laboratories, 4501 Colorado Blvd., Los Angeles 39, Calif.**

For more details circle #461 on mailing card.

(Continued on page 230)

Miniature Tape Recorder Is Battery-Powered

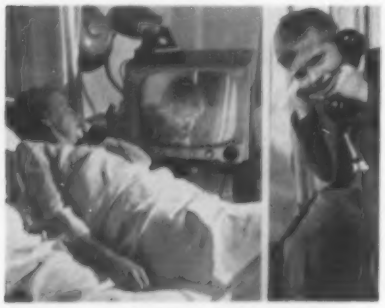
The Dictet Recorder is a battery-powered unit which weighs only slightly more than two and one-half pounds. It is a portable tape recorder made largely of magnesium with a completely transistorized amplifier. It is truly portable and designed for voice recording at any time or place. Controls for starting and stopping, recording, power rewinding and playback are simple and functional and the magazine-loaded magnetic tape holds a full hour of recording.

The new Dictet can be converted into a transcribing machine through use of small plug-in attachments. Tapes can be re-used endlessly. **Dictaphone Corp., 420 Lexington Ave., New York 17.**

For more details circle #462 on mailing card.

WHAT'S NEW

"Visit-Vision" TV For Patient's Visitors



Visitors who are not permitted in patients' rooms for one reason or another, can now visit by television. The new Dage closed-circuit "Visit-Vision" television system makes it possible for children to "visit" patients from the waiting room or other central area. Parents thus see the children and are relieved of possible anxiety as to their condition. Also patients in isolation can have "visits" from family and friends through the Visit-Vision system.

The unit has a self-contained camera, monitor and a special booth for visitors. The viewing unit is placed at the patient's bedside with the visitor's unit in an area designated by the hospital. **Dage Television Division, Thompson Products, Inc., Michigan City, Ind.**

For more details circle #463 on mailing card.

Increased Glare Shade in LSA Sunscreen

The new LSA KoolShade Sunscreen provides high glare-shading efficiency. The new material used in the shade is described as ideal for glare control to properly daylight patient's rooms and other areas of the hospital. The screen is designed to protect windows against the build-up of excessive solar heat and glare at all hours of the day, and all seasons of the year.

Virtually all the outward visibility of regular screening is permitted with the new LSA KoolShade, yet it is said to afford greater protection against heat than a structural overhang. Installed flush to the outside of the windows, the new screen requires no tilting or other adjustment. The unique 24 degree eclipse angle provided by the tiny tilted louvers of the screen gives the cooling effect, maintains proper illumination levels and protects furnishings from sun fading. **KoolShade, Reflectal Corporation, 310 S. Michigan Ave., Chicago 4.**

For more details circle #464 on mailing card.

Reach-In Refrigerator Has Interchangeable Interiors

Interchangeable interiors that are adjustable on one inch centers are the feature of the new Vimco Model RS-40-S Reach-In Refrigerator. Any combination of pan slides, stationary or pull-out meat rails or shelves and refrigerated drawers can be accommodated in the new model. Interior accessories are changed quickly without the use of tools. Ball bearing pull-out shelves permit easy access to items stored at the rear and give increased usable space in the refrigerator.

The RS-40-S has all-metal construction, automatic self-defrosting, automatic interior lighting and a sanitary bottom which is easily wiped clean. Slide-out compressors facilitate servicing in the units which have a capacity of 40 cubic

feet. All interior corners are coved, ground, welded and polished. All doors are equipped with built-in cylinder locks and heavy die-cast handles. **Victory Metal Mfg. Corp., Plymouth Meeting, Pa.**

For more details circle #465 on mailing card.

WHAT'S NEW

Rubber Adapter for Institutional Casters

A new expanding rubber adapter is now available for use with Darnell Institutional Casters. It is offered in sizes for all popular tube dimensions, both round and square. The rubber has a high compression ratio to permit its use for long periods in the tubing without losing its elasticity. It is designed to give added strength to the metal, eliminating undue strain. The adapter is easily installed and contacts the tubing at two points. **Darnell Corp., Ltd., 12000 Woodruff Ave., Downey, Calif.**

For more details circle #466 on mailing card.

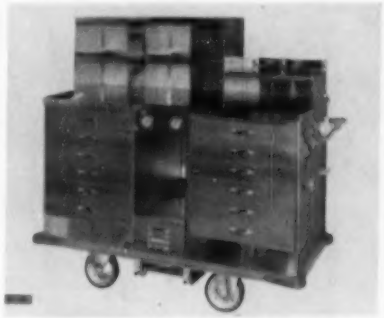
Heat-Treating Process for Silk Sutures

A special heat-treating process is used for the finish on Champion serum-proof silk sutures. Known as Cerethermic Finish, it maintains and preserves suture strength after sterilization, provides superior handling qualities and gives a special smoothness to the sutures. It is designed to facilitate operating room procedures for both the supervisor and the surgeon. Sutures with the new finish are supplied Color-Coded, in the presterilized Dri-Pak, in cut lengths ready for use. **Surgical Div., Gudebrod Bros. Silk Co., Inc., 225 W. 34th St., New York 1.**

For more details circle #467 on mailing card.

Aloe Food Carrier Handles Hot and Cold Foods

Hot foods retain their heat without losing their original flavor, and cold foods stay fresh and chilled in the new Aloe CF 7154 Food Carrier. Temperatures are maintained during the hour or two required for distribution and service to patients' rooms by a super-heated plate in an isolated, insulated space at the bottom of the heated side, from which heat is distributed by a thermostatically controlled damper. The refrigerated side is equipped with a ⅓ h.p. refrigerating unit with the conventional cooling coils and a large cold plate at the top to hold refrigerator temperatures while the carrier is detached from the power supply and in transit.



The carrier is built of stainless steel on an aluminum frame structure. The individual drawers may be readily removed for cleaning and the entire unit is easily kept clean. The superstructure has compartments for silver, doilies, napkins, condiments, cups and other accessories with the top left free for tray assembly. The eight inch, ball bearing, rubber-tired wheels make the carrier easy to move. Walls and door frame are protected by a rubber bumper. The carrier is designed for use with the Aloe Service Pantry and the Soiled Tray Truck for complete and efficient food service. **A. S. Aloe Co., 1831 Olive St., St. Louis 3, Mo.**

For more details circle #468 on mailing card.

(Continued on page 232)

WHAT'S NEW

Lightweight Cleaner for Dry Pick-Up

The new D-110 vacuum cleaner is an inexpensive, lightweight unit for dry pick-up. It is readily portable and equipped with a 30 foot, 18 gauge, 3 conductor cord of non-marking rubber with molded rubber plug. A strain reliever cushions the cord against sudden pulls and strains. The vacuum cleaner weighs only 29 pounds and is easily rolled in any direction desired on four swivel-type casters.

Powered by a universal type ½ h.p. motor, suction is created by a two-stage turbine which develops a 66 inch water lift at the end of a 1½ inch hose, eight feet long, with closed orifice. The all-welded steel tank has ½ bushel capacity. A perfect seal between tank and cover is ensured through the use of easy on-off latches. **Multi-Clean Products, Inc., 2277 Ford Pkwy., St. Paul 1, Minn.**

For more details circle #467 on mailing card.

Water Conditioner Features New Collection System

A new water collection system makes possible more efficient softening of water per pound of mineral used in the new Culligan water softeners and conditioners. Finely slotted manifolds spaced six inches apart at the bottom of the tank make up the new collection system. Water thus passes through the entire mineral bed, eliminating the possibility of a downward channel.

A feature on the new Culligan models tells at a glance the amount of softened water used, giving the user a check on the amount of water available before the next regeneration cycle must be performed. The new line is available in twelve model sizes. **Culligan, Inc., Northbrook, Ill.**

For more details circle #470 on mailing card.

Occasional Chair in Modern Design

The Blactone Occasional Chair, Model 5450, is an addition to the line of modern tubular frame Howell furniture. The comfortable arm chair has No-Sag springs in a deep seat. It is especially suited to use in waiting and reception rooms as well as in patients' rooms and nurses' homes. The curved, form-fitting back is affixed by curve-around tubular frame and braces. The modern Blactone tubular legs are welded into a one-piece frame for strength and rigidity. Genuine brass leg ferrules accent the black legs and add to the attractive appearance.

The contour curving arm rests are upholstered, as are the seat and back, in DuPont breathable Fabrilite, an elastic supported vinyl plastic that resists soil and is easily cleaned. The new chair is available in a choice of more than 35

colors and patterns. Other pieces in the Blactone line have similar design to make possible the attractive room arrangement pictured. **The Howell Co., St. Charles, Ill.**

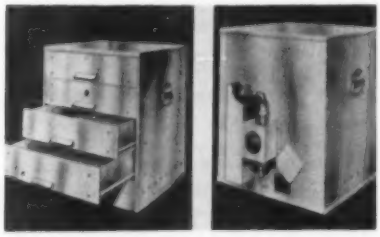
For more details circle #471 on mailing card.

WHAT'S NEW

Heated Food Carrier Cabinets Carry Their Own Fuel

Model H-331-G is a portable propane heated food carrier cabinet of the self-contained drawer type. It is heated evenly and thoroughly by a fixed burner with a controllable flame. The fuel supply of LP gas is carried as a part of the unit and one bottle lasts from 12 to 18 hours of continuous operation. The Cres-Cor "Hot Stuff" portable cabinets are designed for carrying food from central kitchen operations. Food is transported and served hot, with no preheating or reheating.

Hot food is arranged in drawers in the cabinets, ready for serving. Safety stops on the drawers prevent their being ac-



cidentally pulled out. The mobile cabinets are especially useful where food must be transported between buildings. **Crescent Metal Products, Inc., 18901 St. Clair Ave., Cleveland 10, Ohio.**

For more details circle #472 on mailing card.

Maintenance Tower Can Be Raised and Lowered

The new hydro-electric elevating work tower can be plugged into any standard electric outlet and is powered by a ¾ h.p. single phase electric motor. The ML-4-AC Moto-Lift has 50 feet of heavy duty extension cable, permitting work along a 100 foot strip before moving to another outlet. The platform can be raised from seven to seventeen feet above the floor for overall general maintenance.

The tower is easily operated and manned by one person. A foot button on the platform is pressed to control elevation and lowering. The 30 inch square work platform is of heavy metal plate with supports from the sturdy tubular leg base to each corner. The tower is engineered for safety. **Safway Steel Products, Inc., 6234 W. State St., Milwaukee 13, Wis.**

For more details circle #473 on mailing card.

Emergency Unit for Oxygen and Resuscitation

The McKesson Emergency Oxygen and Resuscitation Unit is readily portable and occupies minimum space in use and in storage. In addition to supplying oxygen in emergencies, it can be used as a resuscitator by squeezing the re-breathing bag, thus forcing oxygen into the lungs of the patient. The flow valve and

(Continued on page 234)

yoke are made as a single unit, ensuring a leakproof application to the cylinder. The flow valve is graduated with an

adjustable zero position, thus always indicating the approximate flow rate. Protection against excessive flow rates is afforded by the design of the control valve stem which cannot be opened more than one turn.

The unit is attached to a portable carrier stand, designed for ease in carrying. The handle is correctly positioned for perfect balance and the carrier can be used for either D or E size cylinders. Rubber feet prevent marring any polished surface on which it might be placed. The No. 310 unit is also available without the tank carrier for attachment to a large oxygen cylinder. **McKesson Appliance Co., 2226 Ashland Ave., Toledo 10, Ohio.**

For more details circle #474 on mailing card.

WHAT'S NEW

Pharmaceuticals

Pulvules Paskate

Pulvules Paskate offer a new form of potassium salt therapy for tuberculosis patients intolerant to paraaminosalicylic acid or its sodium salt. It is highly soluble, giving high blood concentrations of PAS, and contains no water or hydration. The pulvule form eliminates any disagreeable taste and makes the medication easy to take. Paskate is indicated as an adjunct to the use of INH, streptomycin and/or dihydrostreptomycin in the treatment of tuberculosis. It is also recommended for patients who must be on restricted sodium diets. **Eli Lilly & Co., Indianapolis 6, Ind.**

For more details circle #475 on mailing card.

Cathomycin

Cathomycin is a new antibiotic for use in treating infections caused by certain bacteria that have become resistant to other antibiotics. It has proved particularly effective against staphylococci as well as against certain urinary tract infections caused by Proteus vulgaris. Cathomycin is rapidly absorbed by the body following oral administration and is described as having a high degree of safety when given in therapeutic doses. **Sharp & Dohme, Division of Merck & Co., Inc., 640 N. Broad St., Philadelphia 1, Pa.**

For more details circle #476 on mailing card.

Cordex Forte Tablets

Cordex Forte Tablets combine steroid and salicylate medication in a new and more potent formula. Three times as much prednisolone is contained in the new tablets as in the original Cordex Tablets. The new tablets are basically prednisolone with activity enhanced with aspirin. They have been found particularly useful for maintenance therapy in rheumatoid arthritis and various other painful conditions affecting the musculoskeletal system. They are available in bottles of 100 or 500 scored tablets. **The Upjohn Company, Kalamazoo, Mich.**

For more details circle #477 on mailing card.

Medihaler

Medihaler is a new device designed to deliver measured doses of asthma medication to the lung in a cloud of minute particles, enabling the drug to produce a relaxing effect on the affected areas. With the Medihaler the medication is self-powered through the use of inert propellants and expanded 275 times its normal size when released. It is available in a pocket sized shatterproof container and requires no bulb to squeeze. A metered dose valve which cannot leak or spill is operated with one stroke of the finger to supply the required dosage. The nebulizer is made of unbreakable plastic and is easily cleaned or sterilized.

Developed for use with the Medihaler Oral Adapter are two products for the relief of symptoms in asthma: Medihaler-Iso™ and Medihaler-Epi™. The medication is administered through the Medihaler so that containers need never be opened or exposed to air and therefore the contents cannot deteriorate. **Riker Laboratories, Inc., P. O. Box 3157 Terminal Annex, Los Angeles 54, Calif.**

For more details circle #478 on mailing card.

E. Coli Diagnostic Serums

E. Coli Diagnostic Serums are additions to the line of Lederle diagnostic agents. They are designed for the laboratory identification of Escherichia coli antigens in freshly isolated living cultures, by means of macroscopic slide agglutination test procedures. **Lederle Laboratories Div., American Cyanamid Co., Pearl River, N.Y.**

For more details circle #479 on mailing card.

Donnagesic Extentabs

Donnagesic Extentabs, designated as No. 1 and No. 2 according to potency, provide an extended action codeine. The analgesic effects are sustained smoothly for 10 to 12 hours with one tablet. The new Extentabs are described as being antitussive, spasmolytic and sedative as well as analgesic. **A. H. Robins Co., Inc., Richmond 20, Va.**

For more details circle #480 on mailing card.

WHAT'S NEW

Literature and Services

• **Resuscitation for Cardiac Arrest"** is the title of a new 20-minute color film directed by Dr. Claude S. Beck, Professor of Cardiovascular Surgery at Western Reserve University. The film shows, through a graphic patient demonstration, the immediate actions that may restore the heart beat. It was produced in cooperation with the Cleveland Area Heart Society under the sponsorship of E. R. Squibb & Sons, 745 Fifth Ave., New York 22.

For more details circle #481 on mailing card.

• Ross Laboratories, 625 Cleveland Ave., Columbus 16, Ohio, manufacturer of Similac Powder and Similac Liquid, offers the report of the Nineteenth Ross Pediatric Research Conference in a booklet, **"Metabolism and Function of Iron."**

For more details circle #482 on mailing card.

• The colors and patterns of **St. Regis Panelyte Decorative Laminated Plastic Surface** are illustrated in an 8-page catalog available from St. Regis Paper Co., 230 Park Ave., New York 17. Printed in full color, the catalog carries illustrations of St. Regis Panelyte in use in institutions, line drawings showing Panelyte installation details and charts giving test and application data on this attractive, impervious laminating material.

For more details circle #483 on mailing card.

• **Catalog No. 120,** illustrating and describing the complete and extensive Shampaine hospital and institutional equipment line, is now available from Shampaine Co., 1920 S. Jefferson Ave., St. Louis 4, Mo. It is described as a "quick, ready reference source of equipment information whether you are planning a completely new construction project, expansion program, or replacement of a single piece of equipment." A helpful arrangement is offered by tabbed dividers which sectionalize the catalog by categories of equipment, all in numerical sequence. The book is printed in black and white and color and is fully indexed.

For more details circle #484 on mailing card.

• **"Would You Spend 10 Minutes a Day to Cut Air Conditioning Water Treatment Costs?"** is the challenging title of a folder recently issued by Oakite Products, Inc., 118A Rector St., New York 6. The folder discusses a mildly alkaline compound known as Oakite Airefiner No. 52, designed to control scale, slime, algae and corrosion.

For more details circle #485 on mailing card.

• A folder on **"The New Line of Champion Dish Washing Machines"** is available from Champion Dish Washing Machine Co., Erie, Pa. Various models of dishwashing machines are pictured with construction features described.

For more details circle #486 on mailing card.

• A new periodical, **Pediatric Patterns,** is being published by Parke, Davis & Company, Detroit 32, Mich. It will include last-minute reports on communicable diseases and infections and will be circulated at regular intervals to physicians in the United States, Alaska and the Hawaiian Islands. The six-page publication is designed to enable physicians to determine the incidence of communicable diseases in any given area.

For more details circle #487 on mailing card.

• The line of kitchen machines available from Toledo Scale Co., Toledo 1, Ohio are described in a new condensed catalog, **Form SD-3815b.** Choppers, a meat and food mixer and large disposers are shown for the first time. The colorful booklet also describes dishwashers, slicers, saws and steak machines.

For more details circle #488 on mailing card.

• The use of Pacific steel boilers for heating schools, hospitals and other institutions is discussed in **Catalog AP-237-F** issued by the Pacific Steel Boiler Div., National-U.S. Radiator Corp., Johnstown, Pa. The 44 page catalog presents ratings and capacities, plus dimensions and engineering data for the complete line of Pacific steel boilers. The ease of installation in new buildings of Pacific boilers and for replacement jobs in old buildings is discussed.

For more details circle #489 on mailing card.

(Continued on page 236)

WHAT'S NEW

• The **"Dietary Catalog Section"** is the first in a series of complete food service equipment catalog information to be offered by Jarvis & Jarvis, Inc., Palmer, Mass. This dietary section describes dish and utility trucks, dish storage trucks, nesting trucks, tray trucks, electrically heated tray conveyors, ice trucks and kitchen trucks. The 20-page catalog includes information for both bumpered and unbumpered models along with dish and utility truck accessories, besides complete specifications, dimensions, shipping weights and shelf sizes.

For more details circle #490 on mailing card.

• A new line of "Design-it-Yourself" carts and trucks is offered by Lakeside Mfg. Inc., 1977 S. Allis St., Milwaukee 7, Wis. A **"Design-it-Yourself" Kit** includes catalog pages, specifications and price information on the line and explains how users can specify any style and number of shelves in five basic sizes. Shelf spacing, overall height, bumper equipment and type and size of casters are also specified on the order form and equipment is custom-made to fit specific needs at very little increase in price over regular production-line models.

For more details circle #491 on mailing card.

• New designs and construction details of **aluminum railings** are contained in a 44-page catalog issued by Blumcraft of Pittsburgh, 460 Melwood St., Pittsburgh 13, Pa. Information on the new low-cost Tube-Line railings for service stairs and other locations where cost is a limiting factor is also included. All Blumcraft aluminum railings are supplied to ornamental metal fabricators who build the railings on the job.

For more details circle #492 on mailing card.

• An attractively printed 12-page catalog of **"Complete Lighting for Hospital Rooms"** is available from Luminous Equipment Co., 1325 W. Webster Ave., Chicago 14. Photographs of special hospital lighting in use are used on the cover which states that "Since 1925 hospital room lighting is our business exclusively." Complete specifications on all types of lights are given together with line drawings of installations details and photographs of the various uses to which the lights can be put.

For more details circle #493 on mailing card.

• **How to plan shelving installations to fit over 1000 storage needs** is simplified by the new shelving catalog released by Hallowell Division, Standard Pressed Steel Co., Jenkintown, Pa. Sample drawings of basic units and accessories with step-by-step explanation, suggested floor plans, a shelf-capacity chart and photographs of complete units show how shelving can be built from the simplest post-and-shelf arrangement to a complicated enclosed unit with sliding or swinging doors.

For more details circle #494 on mailing card.

• The attractive line of "furniture for the modern hospital" offered by Hill-Rom Company, Inc., Batesville, Ind., is covered in the new 44 page **"Hill-Rom Contemporary Catalog Supplement"** recently released. Attractively laid-out and printed in black and white and color, the catalog illustrates and describes all items in the Hill-Rom 8000 Series. It is wire bound to lie flat when open.

For more details circle #495 on mailing card.

• Azrock resilient floor tile is presented in three new folders released by Uvalde Rock Asphalt Co., Azrock Products Division, Frost Bank Bldg., San Antonio 6, Tex. Specifications on the complete line of **Azrock Asphalt Tile** are given in a four page catalog sheet illustrated in full color. **Azrock Asphalt Tile Terrazzo Tones** are shown, with suggested uses, in a second folder. The third new folder shows the complete line of **Azphlex Vinylized Tile,** both Terrazzo and Marble Tones.

For more details circle #496 on mailing card.

• **"Modern Floor Maintenance"** is the title of a new 16 mm motion picture which demonstrates the right and wrong methods of cleaning and polishing floors. Filmed in color with sound, it covers pictorially as well as in narration many of the common problems of daily touch-up maintenance of floors. Interesting sidelights include the care and handling of equipment and simple rules for safety. The film, available through Walter G. Legge Co., Inc., 101 Park Ave., New York 17, is designed to aid administrative personnel in the training of maintenance and cleaning crews.

For more details circle #497 on mailing card.

• **Trion Electronic Air Cleaners** for installation in ventilating system air returns for dirt removal are described in a catalog available from Trion, Inc., 1000 Island Ave., McKees Rocks, Pa. The new 12-page booklet also contains complete engineering data, size and capacity tables and component parts information of particular interest to engineers and architects.

For more details circle #498 on mailing card.

• The catalog folder on **Mercury fluorescent lighting fixtures** has been revised by Smithcraft Lighting Division, Chelsea 50, Mass. The new folder contains construction details, photometric data and complete specifications of the Mercury fixtures.

For more details circle #499 on mailing card.

• Comprehensive technical information on the complete range of **Barnstead Water Stills** is available in a new 48-page catalog published by the Barnstead Still & Sterilizer Co., 124 Lanesville Terrace, Boston 31, Mass. A pictorialized description of "How a Barnstead Still Operates" is a feature of the catalog.

For more details circle #500 on mailing card.

• The full line of surgical instruments and hospital equipment manufactured by the Orthopedic Frame Co., Kalamazoo, Mich., is illustrated and described in a new **1956-57 Catalog.** The 24-page catalog is printed in two colors and is designed to provide essential information for hospital purchasing executives, surgeons and others responsible for the purchase and use of equipment and supplies for orthopedic, plastic and reconstructive surgery, pathology, dermatology, ophthalmology and similar professional practices.

For more details circle #501 on mailing card.

• Emergency standby electric power is the subject of the brochure, **"Emergency Electric Power for Your Hospital,"** available from Detroit Diesel Engine Division, General Motors Corp., Detroit 28, Mich. Units ranging from 20 to 245 KW are described and typical hospital installations are discussed and illustrated.

For more details circle #502 on mailing card.

• Information on **Chef-Styled Commercial Aluminum Cookware** is contained in **Catalog No. 56** released by Harlow C. Stahl Co., 1375 E. Jefferson Ave., Detroit 7, Mich. The complete line of aluminum pots, pans, boilers, bake and roast pans, coffee makers and accessories is described and illustrated with complete specifications.

For more details circle #503 on mailing card.

Book Announcements

Sadove and Cross, "The Recovery Room, Immediate Postoperative Management," with contributions by 24 authorities, 597 pp., $12. "Collected Papers of the Mayo Clinic and the Mayo Foundation," Volume XLVII, 1955, 791 pp., $12.50. **W. B. Saunders Co., W. Washington Square, Philadelphia 5, Pa.**

For more details circle #504 on mailing card.

Suppliers' News

The Diversey Corp., 1820 Roscoe St., Chicago 13, manufacturer of specialized chemicals for sanitation and maintenance, announces the opening of a **New England States office at 101 Tremont St., Boston 8, Mass.**

Southern Equipment Co., manufacturer of "Custom-bilt by Southern" food serving equipment, announces removal of all offices and factories to a new modern building at **4550 Gustine Ave., St. Louis 16, Mo.**

Ohio Chemical Pacific Co., Pacific division of Ohio Chemical & Surgical Equipment Co., Madison, Wis., manufacturer of medical gases and equipment, announces the opening of a completely new and modern plant for the manufacture of medical gases, together with new offices and warehouse at **1231 Second St., Berkeley 10, Calif.**

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PERMIT NO. 137
SEC. 34.9 P. L. & R.
CHICAGO, ILL.

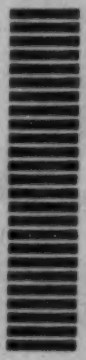
BUSINESS REPLY CARD
No Postage Stamp Necessary if Mailed in the United States

3 CENT POSTAGE WILL BE PAID BY

THE MODERN HOSPITAL

919 NORTH MICHIGAN AVENUE

CHICAGO 11, ILLINOIS



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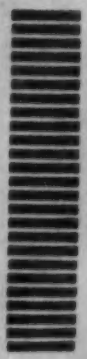

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432 Washer-Pressure Sterilizer
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433 Acoustical Tile
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436 Aluminum Tote Box
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446 Oxygen Analyser
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447 Room Air Conditioners
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448 Tempo-Trays
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449 Green Quarry Tile
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451 Royal-Aire Conditioners
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454 Trend China
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458 Universal Wrench
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August, 1936

Please ask the manufacturers, indicated by the numbers I have circled, to send further literature and information provided there is no charge or obligation.

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PREFERRED
for CASSEROLE COOKERY

OVAL FISH CASSEROLE

OVAL CASSEROLE—HANDLED

SAY-HANDLE CASSEROLE

NEW YORK CASSEROLE

ROUND CASSEROLE

INDIVIDUAL STEW POT—HANDLED

INDIVIDUAL CASSEROLETTE

The chef who takes pride in his recipes knows that the full flavor is preserved if preparation and serving is done in Hall ware. Hall China lasts longer . . . cannot absorb . . . is easy to clean . . . keeps its fresh new look permanently. It is the only china made by our single-fire process which inseparably fuses body, glaze, and color.

Write for Bulletin SM-1 which lists and illustrates Hall casseroles, baking dishes, coffee and teapots, creamers, jugs, ash trays, salads, and many other items available in 26 beautiful underglaze colors.

THE HALL CHINA COMPANY · EAST LIVERPOOL, OHIO

The World's Largest Manufacturer of Fireproof Cooking China

FRENCH CASSEROLE—SIDE HANDLED

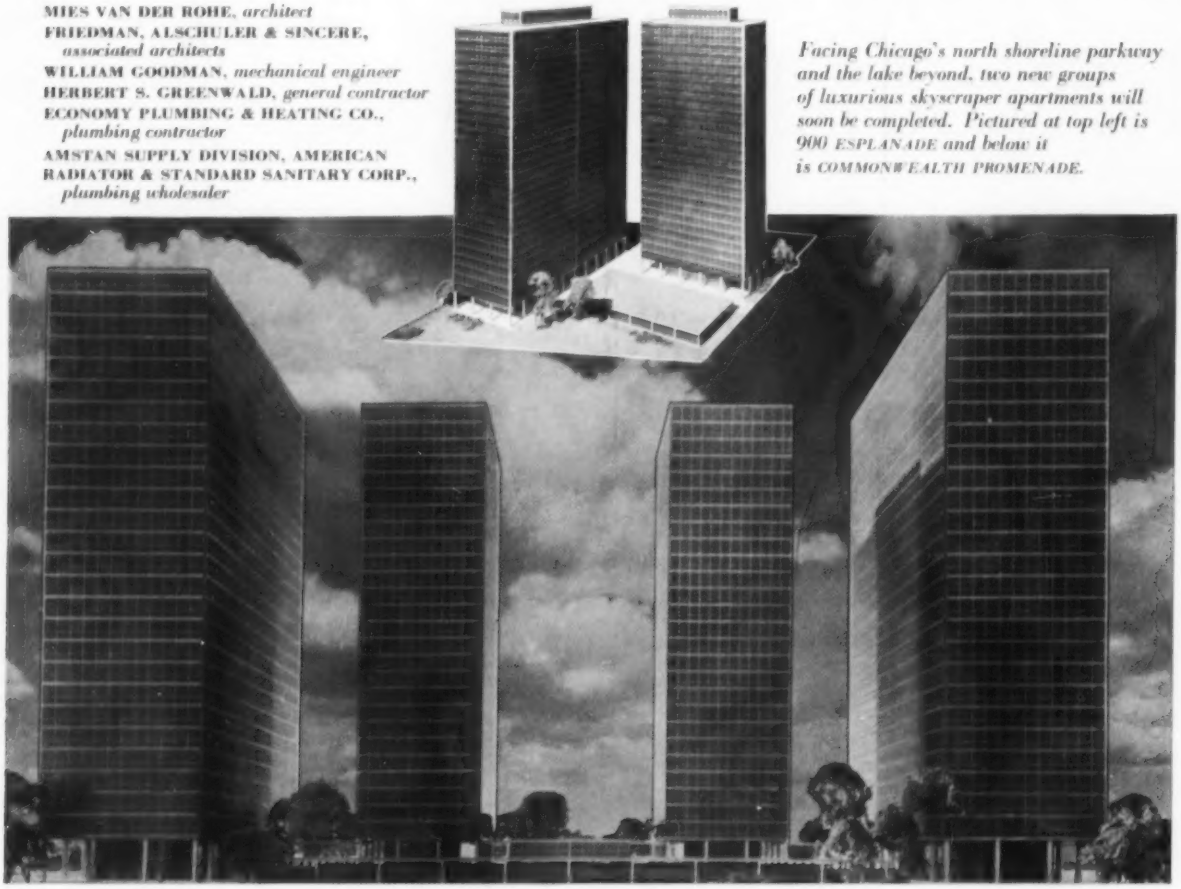
Hall China casseroles are available in sizes ranging from individual to banquet service.

Each Hall Casserole is individually hand finished, by a skilled craftsman, before glaze is applied.

THE VAST MAJORITY OF THE NATION'S FINE BUILDINGS ARE SLOAN EQUIPPED

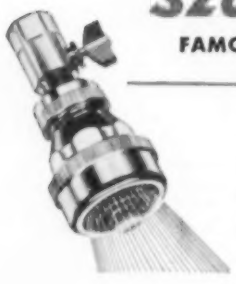
MIES VAN DER ROHE, *architect*
FRIEDMAN, ALSCHULER & SINCERE, *associated architects*
WILLIAM GOODMAN, *mechanical engineer*
HERBERT S. GREENWALD, *general contractor*
ECONOMY PLUMBING & HEATING CO., *plumbing contractor*
AMSTAN SUPPLY DIVISION, AMERICAN RADIATOR & STANDARD SANITARY CORP., *plumbing wholesaler*

Facing Chicago's north shoreline parkway and the lake beyond, two new groups of luxurious skyscraper apartments will soon be completed. Pictured at top left is 900 ESPLANADE and below it is COMMONWEALTH PROMENADE.



NEW GLAMOUR ON CHICAGO'S GOLD COAST

• On the two largest unoccupied building sites on Chicago's "Gold Coast," overlooking Lake Michigan, a $25-million, 6-building apartment enterprise is rapidly nearing completion. These 28 and 29 story towers will be the tallest flat-slab reinforced concrete structures in the U.S. and possibly the world. Prefabricated skin frames of aluminum, each a story high, will hold crystal walls of gray tinted, heat retarding plate glass. All of the 1238 apartments (6108 rooms) will be summer and winter air-conditioned and equipped with individual room controls. All will feature maximum soundproofing for quiet privacy. All will be served by high speed, electronically teamed elevators and all corridors will be pressurized. In a project of such fabulous designing nothing less than the best would suffice, hence all towers are to be equipped throughout with SLOAN *Quiet Flush* VALVES and SLOAN *Act-O-Matic* SHOWER HEADS.



SLOAN *Flush* VALVES

FAMOUS FOR EFFICIENCY, DURABILITY, ECONOMY

SLOAN VALVE COMPANY • CHICAGO • ILLINOIS

Another achievement in efficiency, endurance and economy is the SLOAN *Act-O-Matic* SHOWER HEAD, which is automatically self-cleaning each time it is used! No clogging. No dripping. Architects specify, and Wholesalers and Master Plumbers recommend the *Act-O-Matic*—the better shower head for better bathing.

Write for completely descriptive folder